

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05317

CERTIFICATE OF DEATH

05278

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLARKSBURG</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Clarksburg</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>138 Hammond Dr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>S.</u> Last <u>Benson</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30 - 1879</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm labor</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John E. Benson</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Dowden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT Address <u>Clarksburg Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year <u>May 17, 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 17, 1957</u> to <u>May 30, 1957</u> , that I last saw the deceased alive on <u>May 30, 1957</u> , and that death occurred at <u>Md.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James P. Kerr</u> M.D.		ADDRESS (Street, city or town, state) <u>Damascus, Md.</u> DATE SIGNED <u>6/1/57</u>	
PHYSICIAN'S NAME (Type) <u>JAMES P. KERR M.D.</u>		<u>DAMASCUS, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Neelsville</u>	22d. LOCATION (City, town, or county) (State) <u>Neelsville - Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oroya Barber</u> ADDRESS <u>Laytonsville</u>		24a. REC'D BY REGISTRAR <u>June 4/57</u> 24b. REGISTRAR'S SIGNATURE <u>Della V. Burdette</u>	

# CERTIFICATE OF DEATH

STATE OF NEW YORK

NO. 10

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 7 Film 215 5-17-57 et

05318

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05279

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>11819 Drummond Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Edwin</u> <u>BERRY</u>				4. DATE OF DEATH Month Day Year <u>May</u> <u>2</u> <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 24, 1905</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Representative</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Charles Edwin</u>				14. MOTHER'S MAIDEN NAME <u>Edna Parmeter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Reserve</u>				16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Address <u>Helen K. Berry- Item # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>444X</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>4/28, 1957</u> to <u>5/2, 1957</u> , that I last saw the deceased alive on <u>5/2, 1957</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr Joseph Kennick</u>				ADDRESS (Street, city or town, state) <u>6450 Wisconsin Ave, Bethesda, Md</u>			
DATE SIGNED <u>5/2/57</u>							
PHYSICIAN'S NAME (Type) <u>Dr JOSEPH KENRICK</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Aspen Hill, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>7-7-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

# CERTIFICATE OF DEATH

BUREAU V. S.

MAY 9 1957

RECEIVED



## 05319 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>4 mos. 4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>211 Scott Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joanne</u> Middle <u>Carol</u> Last <u>BESSETTE</u>		4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 Dec. 1955</u>
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alfred C. Bessette</u>		14. MOTHER'S MAIDEN NAME <u>Ella Parks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>(Father) Alfred C. Bessette (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SARCOMA BOTRYOIDES</u> <u>233x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). INTERVAL BETWEEN ONSET AND DEATH <u>12 MONTHS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>18 Dec.</u> , 19 <u>56</u> , to <u>9 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9 May 1957</u> , 19 <u>57</u> , and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Daniel Shupfart</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>5-10-57</u> PHYSICIAN'S NAME (Type) <u>Daniel Shupfart, LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-14-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Humphrey</u>		ADDRESS <u>7557 Wisconsin Ave., Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>5-10-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Connelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH AND DEATH RECORDS

BUREAU V. 21

MAY 13 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 05320 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05281

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1019 QUEBEC TERRACE</b>				d. STREET ADDRESS <b>1019 QUEBEC TERRACE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ARNOLD</b> Middle <b>STEWART</b> Last <b>BLACK</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>30</b> Year <b>19 57</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 2, 1957</b>		9. AGE (In years last birthday) <b>28</b> yrs.		IF UNDER 1 YEAR: Months <b>1</b> Days <b>28</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RONALD ALLEN BLACK</b>				14. MOTHER'S MAIDEN NAME <b>BEVERLY SOKOL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Mr. Ronald Allen Black, 1019 Quebec Terrace Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b>  <b>475X</b> DUE TO <b>Upper Respiratory Infection</b>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b></b>            DUE TO <b></b>            (c) <b></b> </p> </div> <div style="width: 35%; text-align: right;"> <p>INTERVIEW BETWEEN ONSET AND DEATH  <b>Fond died in bed</b> </p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>					
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) <b></b> (County) <b></b> (State) <b></b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/31/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>National Capitol Hebrew</b>		22d. LOCATION (City, town, or county) <b>Washington, D. C.</b> (State) <b></b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Banzan &amp; Sons</b> ADDRESS <b>3501 14th St., N.W.</b>				24a. REC'D BY REGISTRAR <b>DATE 5/31/57</b>		24b. REGISTRAR'S SIGNATURE <b>Frances Potter</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUN 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05282

05321

## CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
c. LENGTH OF STAY IN 1b <u>9 months</u>				d. STREET ADDRESS <u>1368 East Capitol</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4220 Brookfield Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dora</u> First <u>L</u> Middle <u>Bond</u> Last				4. DATE OF DEATH <u>May 7</u> Month <u>May</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 10, 1879</u> 78 yrs.	
9. AGE (In years last birthday) <u>78</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adolph Lindenbahl</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Prager</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				17. INFORMANT <u>Pauline Refaratti</u> Address <u>1368 East Capitol</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> (c) <u>Generalized arterio sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan.</u> , 1957, to <u>May 7</u> , 1957, that I last saw the deceased alive on <u>May 6</u> , 1957, and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6300-13th St. NW, Wash. D.C.</u> DATE SIGNED <u>5/7/57</u> ACTUAL SIGNATURE <u>Walter K. Angevine</u> , M.D. PHYSICIAN'S NAME (Type) <u>Walter K. Angevine M.D.</u> 6300 13th St N.W. Washington? D C							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5-10-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>	
22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Mattingly</u> ADDRESS <u>131-11th St. N.E.</u>			
24a. REC'D BY REGISTRAR <u>5/10/57</u>				24b. REGISTRAR'S SIGNATURE <u>Frances P. Patton</u>			



CERTIFICATE OF DEATH

BUREAU V. 1

MAY 10 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: For: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05322

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05283

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>6 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		d. STREET ADDRESS <u>1718 Noyes Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1718 Noyes Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence Loretta Bowden</u>				4. DATE OF DEATH Month Day Year <u>May 13 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-29-1872</u>	9. AGE (in years last birthday) <u>85 yrs</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Samuel Brook Roushew</u>				14. MOTHER'S MAIDEN NAME <u>Charity Tensell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>W. F. Roushew - Same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory failure</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular accident</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1/2 day</u> <u>5 1/2 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pheloa Com</u>		22d. LOCATION (City, town, or county) (State) <u>Westport Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward L. ...</u>				24a. REC'D BY REGISTRAR <u>DATE 5/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>Francis ...</u>	

DATE SIGNED

5-13-57

BUREAU V. S.

MAY 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05323

CERTIFICATE OF DEATH

05284

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Burtonsville</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burtonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burtonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph Pompey Bowen</b>		4. DATE OF DEATH Month Day Year <b>May 9 19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/22/1899</b>
9. AGE (In years lost birthday) <b>58</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sight Seeing Guide</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Montross, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph P. Bowen</b>		14. MOTHER'S MAIDEN NAME <b>Annie V. Scates</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <b>577-26-3427</b>	
17. INFORMANT <b>Mrs. Betty Bowen, Burtonsville, Md.</b>		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>585X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Obesity</b> DUE TO (c) <b>Ch. Cholelithiasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4/11/57</b> <b>25 hr</b> <b>4 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/13</b> , 19 <b>57</b> to <b>5/9</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5/6</b> , 19 <b>57</b> , and that death occurred at <b>6:11</b> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>B. P. Warren</b> M.D. <b>Burtonsville Md 5/9/57</b>			
ACTUAL SIGNATURE <b>B. P. WARREN</b>			
PHYSICIAN'S NAME (Type) <b>B. P. WARREN</b>			
22a. BURIAL (If cremation, specify) <b>burial</b>		22b. DATE THEREOF <b>5/11/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pr. Geo. Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.</b>		24. REGISTRAR'S SIGNATURE <b>Wash. D.C. MAY 16 1957</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 10 1957

BUREAU V. S.



em 18 Film 218 7-18-57 ams

05324

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Maryland</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annadale</b>			
d. STREET ADDRESS <b>Route #3 Box 275</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Wade</b> Last <b>BOWMAN</b>				4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>27 Feb. 1917</b>	
9. AGE (In years last birthday) <b>40</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrical</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Commercial</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>George T. BOWMAN</b>				14. MOTHER'S MAIDEN NAME <b>Maude WADE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-II</b>		17. INFORMANT <b>(Brother) Joseph N. Bowman (Same As #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>IP Respiration/ Bilateral confluent lobular pneumonia over 4 days</b> DUE TO <b>Pulmonary edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Hypotension</b> DUE TO (c) <b>Hypotension</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Increased intracranial pressure; fatty degeneration of liver</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>21 May</b> , 19 <b>57</b> , to <b>25 May</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>25 May</b> , 19 <b>57</b> , and that death occurred at <b>1:12 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>5-25-57</b>							
ACTUAL SIGNATURE <b>Burt C. Johnson</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Burt C. Johnson, LCDR, MC, USN</b>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-29-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Deal Funeral Home</b> ADDRESS <b>Wash. D. C.</b>				24a. REC'D BY REGISTRAR <b>5-25-57</b> 24b. REGISTRAR'S SIGNATURE <b>Mary E. Parrelly</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed with the registrar.

page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.

MAY 29 1957

RECEIVED

05325

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) b. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>				c. LENGTH OF STAY IN 1b <u>20 hr. 15 min.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4th &amp; Washington</u>				d. STREET ADDRESS <u>208 10th St., S.E.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>BRANTLEY</u>				4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 May 1957</u>		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel Brantley</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Soggon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT (Father) <u>Samuel Brantley (Same As #1)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia</u> <u>762.00</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Bilateral Fetal Atelectasis</u> (c) <u>20 3/4 hrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 3/4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12 May</u> , 19 <u>57</u> , to <u>13 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>13 May</u> , 19 <u>57</u> , and that death occurred at <u>5:42 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md. 5-15-57</u>							
ACTUAL SIGNATURE <u>John H. Mazur</u> M.D.				U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) <u>John H. Mazur, II, M.D., U.S.N.</u>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edmund H. Hume</u>				ADDRESS <u>1722 7th St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>May 14 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>May 14 1957</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 16 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# 05310 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05287

Reg. Dist. No. 213

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>304 N. Adams St</u>				d. STREET ADDRESS <u>304 N. Adams St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Engene</u> Last <u>Breeden</u>				4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-1919</u>	9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>24</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fire Department</u>		11. BIRTHPLACE (State or foreign country) <u>va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emmet Breeden</u>				14. MOTHER'S MAIDEN NAME <u>Jane Haynes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1945-1946</u>		17. INFORMANT <u>Georgia Breeden - Same as #2</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause lost. DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>5/20/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. Paul Dwyer</u>		DATE SIGNED <u>5-17-57</u>	



BUREAU V. S.

MAY 22 1957

RECEIVED

05311

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>309 Potomac Street</b>				e. STREET ADDRESS <b>309 Potomac Street</b>			
3. NAME OF DECEASED (Type or print) First <b>AMELIA</b> Middle <b>ALEXANDER</b> Last <b>BREWER</b>				4. DATE OF DEATH Month <b>May</b> Day <b>29</b> , Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 13, 1887</b>		9. AGE (in years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>18</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Coleman, Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles M. Alexander</b>				14. MOTHER'S MAIDEN NAME <b>Mary Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Husband</b> <b>Lloyd A. Brewer, Jr.</b>		Address <b>Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Degenerative disease of spinal cord (amyotrophic lateral sclerosis)</b>						INTERVAL BETWEEN ONSET AND DEATH <b>9 hours</b> <b>19 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month _____ Day _____ Year <b>19</b> Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>1950</b> , 19____, <b>May 29</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 29</b> , 19 <b>57</b> , and that death occurred <b>4:0 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wm A. Linthicum</b>				ADDRESS (Street, city or town, state) <b>26 N. Summit Ave. Baltimore, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Wm A. Linthicum</b>				DATE SIGNED <b>5/30/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-1-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Union Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Montgomery County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 3 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>David H. [illegible]</b>			

THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 18 1957

BUREAU V. S.

## 217

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If infirm institution, Residence before admission] o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON.</u>		c. LENGTH OF STAY IN 1b <u>6 months</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING MD</u>		d. STREET ADDRESS <u>614 GIST AVE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDEN. Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCIS M. BRINKLEY</u>		4. DATE OF DEATH Month Day Year <u>MAY 18 1957</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 21. 1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>G.P. ENGINEERING.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>NOV. 21. 1876 WASH DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>SAM. BRINKLEY.</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE JOHNSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>W.</u>	
17. INFORMANT Address <u>MRS AUDREY BURRENS 614 GIST AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cortic embolism</u> <u>432.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>A.S.C.V.D</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 day</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.1</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/18/57</u> , 19 <u>55</u> , to <u>5/18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/18/57</u> , 19 <u>57</u> , and that death occurred at <u>3:45</u> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>12600 PARKLAND PR 5/18/57</u>	
ACTUAL SIGNATURE <u>Charles M Weber M.D.</u>		PHYSICIAN'S NAME (Type) <u>CHARLES M WEBER M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 21, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. D.C</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W Warren attorney</u>		24a. REC'D BY REGISTRAR DATE <u>5/21/57</u>	
ADDRESS <u>3619-14th St NW</u>		24b. REGISTRAR'S SIGNATURE <u>Frederick J. ...</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page [redacted] may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU OF

MAY 20 1957

RECEIVED



05327

## CERTIFICATE OF DEATH

05290

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN TB <b>9 hr. 45 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>				d. STREET ADDRESS <b>5133 North 37th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>BROWNING</b>				4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 26, 1957</b>	
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months		IF UNDER 24 HRS Days		Hours <b>9</b> Min <b>45</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Benjamin Howard BROWNING, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Dorothy LANEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Benjamin H. BROWNING, Jr. (Same as #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Abnormal pulmonary ventilation</b> 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b> DUE TO (c) <b>9 1/4 hrs.</b> INTERVAL BETWEEN ONSET AND DEATH <b>9 1/4 hrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 26</b> , 1957, to <b>May 27</b> , 1957, that I last saw the deceased alive on <b>May 27</b> , 1957, and that death occurred at <b>1:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>John H. Mazur</b>				M.D. <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>John H. MAZUR LT, MC, USN</b>				<b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL. (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-29-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>R. A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>5-28-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary E. Parrelly</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

MAY 29 1957

RECEIVED

MARYLAND

05291  
STATE DEPARTMENT OF HEALTH

## 05328 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Mont</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Mont</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>15 East Lenox</u>	
3. NAME OF DECEASED (Type or Print) <u>Laura Grilstad</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 16 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 15-1865</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>92</u> yrs. If under 1 year: Months Days If under 24 hrs. Min.
13. FATHER'S NAME <u>Grilstad</u>		12. CITIZEN OF WHAT COUNTRY? <u>Norway</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		17. INFORMANT AND ADDRESS <u>Laura Bryn Winslow 15 E Lenox</u>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <u>Samstad</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>3 weeks</u>
(a) Immediate cause <u>Congestive Heart Disease</u>		
(b) Antecedent cause(s) <u>Coronary Thrombosis</u> <u>Generalized Arteriosclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>4-50-0</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>15 E Lenox</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 1954 to May 16, 1957, that I last saw the deceased alive on May 16, 1957, and that death occurred at 12:35 P.m., from the causes and on the date stated above.

SIGNATURE Benjamin M. Thompson (Degree or title) ADDRESS 1912 R St NW DATE SIGNED 5/16/57

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>5/18/57</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	LOCATION (City, town, or county) (State) <u>Montgomery MD</u>
DATE REC'D BY LOCAL REG <u>5-17-57</u>	REGISTRAR'S SIGNATURE <u>Benjamin M. Thompson</u>	24. FUNERAL DIRECTOR <u>Joseph S. Davis</u> ADDRESS <u>1756 Pa Ave, N.E., D.C.</u>	

BUREAU V. E.

MAY 21 1957

RECEIVED

05329

## CERTIFICATE OF DEATH

Iter 11 FILE 0216 6-19-57 et

Reg. Dist. No. 216

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy shall be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brookmont</u>	LENGTH OF STAY (in this place) <u>1 month</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brookmont</u>	TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>6407 McArthur Blvd.</u>	
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b>	
(First) <u>AGNES</u> (Middle) <u>J</u> (Last) <u>BURDETTE</u>		(Month) <u>5</u> (Day) <u>26</u> (Year) <u>1957</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>Dec 27, 1878</u>
<b>9. AGE last birthday</b> <u>78</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>Birmingham, England</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>William B. Johnstone</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Ferguson</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) <u>no</u> (If Yes, give war or dates of service)	
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT'S ADDRESS</b> <u>Mary Burdette same</u>	
<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<u>10 months</u>	
<b>4X IMMEDIATE CAUSE (A)</b> <u>Carcinoma of the rectum</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>			
<b>STATING UNDERLYING CAUSE LAST.</b>			
<b>21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19. DATE OF OPERATION</b> <u>Nov 15, 1956</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>Carcinoma of the rectum</u>	
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)	
<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Aug 1, 1956</u> , to <u>May 26, 1957</u> , that I last saw the deceased alive on <u>May 26, 1957</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.			
<b>SIGNATURE</b> <u>Fred A. Sanderson</u>		<b>DATE SIGNED</b> <u>5-26-57</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>5/29/57</u>	
<b>NAME OF CEMETERY OR CREMATORY</b> <u>Oak Hill Cem.</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Wash. D.C.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Bessie M. Thompson</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ching Chae Fung Hing</u>	
<b>DATE</b> <u>5-29-57</u>		<b>ADDRESS</b> <u>5103 Kisan Wash D.C.</u>	

BUREAU W. A.

3 1957

W. A. BUREAU

05312

## CERTIFICATE OF DEATH

Reg. Dist. No. 13

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>314 Crabb Avenue</u>				d. STREET ADDRESS <u>314 Crabb Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grant</u> <u>Burk</u>				4. DATE OF DEATH Month Day Year <u>May</u> <u>20</u> <u>19 57</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May, 15 1896</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>5</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Parking Attendent</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Parking cars</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Burk</u>				14. MOTHER'S MAIDEN NAME <u>Laurie Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>384-03-4055</u>		17. INFORMANT Address <u>Varnie Burk, as item # 2</u> <u>Wife</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ventricular fibrillation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary atherosclerosis</u> DUE TO <u>Congestive failure x 5 yrs</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>10 yrs</u> <u>5 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/11/1951</u> to <u>5/20/1957</u> that I last saw the deceased alive on <u>5/19/1957</u> and that death occurred at <u>7:30 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen W. Jones</u> M.D.				ADDRESS (Street, city or town, state) <u>Rockville, Md.</u> DATE SIGNED <u>5/20/57</u>			
PRINTED NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>5/20/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Lawrence M. Hargrave</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 31

1957 02 14

RECEIVED



05330

## CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>69 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Childs</b> d. STREET ADDRESS <b>No street address</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph Arvel Canter</b>				4. DATE OF DEATH Month Day Year <b>May 20th 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 13, 1942</b>	9. AGE (In years last birthday) yrs. <b>15</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arvel Canter</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Hodgson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>The Medical Record The Clinical Center, Bethesda, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO (b) <b>Sepsis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Acute Lymphocytic Leukemia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Loss of Gastrointestinal Hemorrhage</b>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 12th, 1957</b> , to <b>May 20th, 1957</b> , that I last saw the deceased alive on <b>May 20th, 1957</b> , and that death occurred at <b>3:05 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Arthur J. Garceau</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b>		DATE SIGNED <b>5/20/57</b>	
PHYSICIAN'S NAME (Type) <b>Arthur J. Garceau, M. D.</b>				The National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>SHIP</b>		22b. DATE THEREOF <b>5-21-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WEST-JEFFERSON</b>		(State) <b>N-C</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. CHAMBERS CO</b>				ADDRESS <b>1400 Chapin St NW</b>		24a. REC'D BY REGISTRAR <b>5/22/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Desa Thompson</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

## 05331 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>207</u> Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>314 Somerset Place, N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>Grant</u> Last <u>CASKEY</u>				4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1957</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-7-1887</u>	9. AGE (In years last birthday) <u>69</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Navy (Retired)</u>		11 BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Floyd W. Caskey</u>				14 MOTHER'S MAIDEN NAME <u>Sara Little</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Official Navy Records</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Official Navy Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>197.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>Metastatic carcinoma (anaplastic)</u> (c) INTERVAL BETWEEN ONSET AND DEATH <u>7 months.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>20 Jan.</u> 19 <u>57</u> to <u>15 May</u> 19 <u>57</u> that I last saw the deceased alive on <u>15 May</u> 19 <u>57</u> and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>5-10-57</u>							
ACTUAL SIGNATURE <u>Russell Miller, Jr.</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>				PHYSICIAN'S NAME (Type) <u>Russell Miller, Jr. LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Miller Co.</u> ADDRESS <u>1414 14th St. N.W., Wash., D.C.</u>				24a. REC'D BY REGISTRAR <u>Mary E. Russell</u> 24b. REGISTRAR'S SIGNATURE <u>Mary E. Russell</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05296

05332

## CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>MONTG.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>E. C.</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda.</u>				c. LENGTH OF STAY IN 1b <u>24 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
f. STREET ADDRESS <u>5168 River Rd</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LOTTIE</u> Middle _____ Last <u>CHAPPEL</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>N. Gro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-00</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>John Hopkins</u>				14. MOTHER'S MAIDEN NAME <u>Jennina (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Aug. M. Chappell</u>				Address <u>5206 1/2 River Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia due to Generalized</u> DUE TO <u>3rd Carcinomatosis -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary Carcinoma of ovary.</u> DUE TO (c) <u>1 month</u> <u>1 month plus</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. _____ p. m. _____ Month, Day, Year _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>May 18, 1957</u> to <u>May 8, 1957</u> , that I last saw the deceased alive on <u>May 4, 1957</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. W. DANISH</u>				M.D. <u>917 Rushing Rd. 5/8/57</u>			
PHYSICIAN'S NAME (Type) <u>A. W. DANISH</u>				DATE SIGNED <u>May 8, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-13-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Phines &amp; Company</u>				ADDRESS <u>901 3rd St., S. W.</u>			
DATE <u>MAY 10 1957</u>				24b. REGISTRAR'S SIGNATURE <u>Beattie Thompson</u>			

RECEIVED

MAY 10 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05297

05333

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>10 DAYS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>7 Galley Road</u>			
3. NAME OF DECEASED (Type or print) <u>Frances Leverage CLARKE</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-28-49</u>		9. AGE (In years last birthday) <u>7</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas T. Clarke</u>				14. MOTHER'S MAIDEN NAME <u>Gaynell I. Kelly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT (Father) <u>Thomas T. Clarke (Same As #)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Atelectasis, Bilateral</u> DUE TO (b) <u>Obstruction of bronchia and left main bronchus by</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>hemorrhage and confusion of brain</u> (c) <u>Depressed skull fracture</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Child running after ball into street, struck by automobile</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>5:00</u> p.m. <u>4-30</u> 19 <u>57</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>California</u> (County) <u>Maryland</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. Frank J. Broschart, MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-2-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Leopardtown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Robinson</u>				24a. REC'D BY REGISTRAR DATE <u>5-1-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
MAY 6 1957  
BUREAU V. S.



05334

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Likemance</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Likemance</u>			
c. LENGTH OF STAY IN 1b <u>7 yrs</u>				d. STREET ADDRESS <u>5212 Nahant St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BENJAMIN</u> Middle <u>JOLIFFE</u> Last <u>CLARK SON</u>				4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 2, 1914</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>3</u>		IF UNDER 24 HRS Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SERVICE MANAGER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SHOE DEPT</u>			
11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>HUGH THOMPSON CLARKSON</u>				14. MOTHER'S MAIDEN NAME <u>MARY JOLIFFE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WORLD WAR 2 - 1941-45</u>				16. SOCIAL SECURITY NO. <u>578-07-9784</u>			
17. INFORMANT <u>AGNES CLARKSON</u>				5212 Nahant St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH <u>10 MOS.</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA</u>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) <u>DUE TO</u>	
						(c) <u>DUE TO</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>July</u> Day <u>19</u> Year <u>1956</u> Hour <u>a.m.</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Pa. Ave. N.W.</u>				(County) <u>WASH. D.C.</u>		(State) <u>WASH. D.C.</u>	
21. I certify that I attended the deceased from <u>JULY 1956</u> 19 <u>56</u> , to <u>MAY 9, 1957</u> , that I last saw the deceased alive on <u>MAY 9, 1957</u> 19 <u>57</u> , and that death occurred at <u>7 P.</u> M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>2540 Pa. Ave. N.W. WASH. D.C.</u>				DATE SIGNED <u>MAY 9, 1957</u>			
ACTUAL SIGNATURE <u>Paul H. Taylor M.D.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>PAUL H. TAYLOR M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Savaris Sons</u>				ADDRESS <u>1756 Pa Ave N.W. DC</u>		24a. REC'D BY REGISTRAR <u>DATE 5-11-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed far use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

13 1957

RECEIVED

05335

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>8 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Maryland</b>				d. STREET ADDRESS <b>5204 28th Parkway</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Bash</b> Last <b>CLEGG</b>				4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 15, 1881</b>	
9. AGE (In years last birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Glass Blower</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Commercial</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Matthew CLEGG</b>				14. MOTHER'S MAIDEN NAME <b>Adaline BASH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b> (If yes, give war or dates of service) <b>-----</b>				16. SOCIAL SECURITY NO. <b>163-24-5725</b>		17. INFORMANT <b>Mrs. Edward Rohrer 308 Claiborne Towers,</b>	
Address <b>New Orleans, La.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carrying at the Liver</b> <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 21, 1957</b> , to <b>May 29, 1957</b> , that I last saw the deceased alive on <b>May 29, 1957</b> , and that death occurred at <b>8:40 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 5-29-57</b>							
ACTUAL SIGNATURE <b>Robert C. Thomas</b> M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>				PHYSICIAN'S NAME (Type) <b>Robert C. THOMAS, M.D.</b> <b>U.S. Naval Hospital, Bethesda, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-4-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Private Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wilkinsburg, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Funeral Home, Good Hope Road, Anacostia</b>				24a. REC'D BY REGISTRAR DATE <b>5-29-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Sorelly</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

1957

RECEIVED

05336

## CERTIFICATE OF DEATH

053006  
216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b>			
d. NAME OF HOSPITAL (If not in hospital, give address of residence) <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Thelma</b> Middle <b>Alegre</b> Last <b>Climenhaga</b>				4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2 December 1917</b>	9. AGE (In years last birthday) <b>39</b> yrs	IF UNDER 1 YEAR Months <b>10</b> Days <b>1</b> Hours <b>1</b> Min <b>0</b>	IF UNDER 24 HRS Months <b>10</b> Days <b>1</b> Hours <b>1</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Unascertainable</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Langford Van Horn</b>				
14. MOTHER'S MAIDEN NAME <b>Sarah Lowther</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. <b>577-18-6236</b>			17. INFORMANT <b>The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>163X</b> DUE TO <b>LUNG</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>METASTATIC CAR. INV. F. T.</b> (c) <b>BRAIN, LIVER AND BONES</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10/1</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>December 27, 1956</b> , to <b>May 29, 1957</b> , that I last saw the deceased alive on <b>May 29, 1957</b> , and that death occurred at <b>4:20 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b> DATE SIGNED <b>5/29/57</b>							
ACTUAL SIGNATURE <b>Gurston Goldin, M. D.</b>							
PHYSICIAN'S NAME (Type) <b>Gurston Goldin, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-1-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek</b>	22d. LOCATION (Only town, or county) <b>Washington, DC</b>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Deaf Funeral Home</b>		ADDRESS <b>4812 Ga An Wash, DC</b>	24. REC'D BY REGISTRAR <b>MAJUN 4 1957</b>	24b. REGISTRAR'S SIGNATURE <b>L. J. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 4 1957

RECEIVED

05289

## CERTIFICATE OF DEATH

Reg. Dist. No.

0530173

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>2 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium &amp; Hospital</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2908 Colombia Rd.</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ronald Burton Conley</b>		4. DATE OF DEATH Month Day Year <b>May 8 19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-10-91</b>
9. AGE (In years last birthday) <b>66</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Thomas Conley</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Manear</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-5840</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/6/57</b> , 19____, to <b>5/8/57</b> , 19____, that I last saw the deceased alive on <b>5/8/57</b> , 19____, and that death occurred at <b>11:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Raymond O. West</b> M.D.			
NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>5/13/57</b>	<b>Moreland Mem.</b>	<b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Brooks Bradley Inc.</b>		ADDRESS <b>Dundalk, Md.</b>	24a. REC'D BY REGISTRAR <b>May 10 1957</b>
		24b. REGISTRAR'S SIGNATURE <b>J. Nelson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 10 1957

RECEIVED



05337

## CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>5 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maudella</u> Middle <u>Rebecca</u> Last <u>Cooper</u>				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/6/98</u>	
9. AGE (In years last birthday) <u>58</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles Watson</u>				14. MOTHER'S MAIDEN NAME <u>Janie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Hospital Record</u> Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carotid Arteriosclerosis</u> DUE TO (b) <u>Arteriosclerosis, Hypertension</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>		20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. <u>  </u> m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>		20g. (County) <u>  </u>		20h. (State) <u>  </u>			
21. I certify that I attended the deceased from <u>5/24</u> , 19 <u>57</u> , to <u>5/27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/27</u> , 19 <u>57</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Maryland</u> DATE SIGNED <u>5/3/57</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u> PREVIOUS NAME (Type) <u>J. W. Bird, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant,</u>		22d. LOCATION (City, town, or county) (State) <u>Norbeck, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swarden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>7</u> 19 <u>57</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. I.

17

MAY 7 1957

RECEIVED

05338

## CERTIFICATE OF DEATH

Reg. Dist. No. 05303 21

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>		c. LENGTH OF STAY IN 1b <b>56 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jacksonville</b>	
3 NAME OF DECEASED (Type or print) First <b>Susan</b> Middle <b>Irene</b> Last <b>WARD Cooper</b>		4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1917</b>
9. AGE (In years last birthday) <b>39</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
11 BIRTHPLACE (State or foreign country) <b>New York</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Rodney Charles Ward</b>		14. MOTHER'S MAIDEN NAME <b>Susan Palmer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>132-07-5369</b>	
17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC &amp; Renal Failure</b> <b>410 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Mitral Insufficiency</b> (c) <b>Rheumatic Heart Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b> <b>1 year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 31, 19 57</b> , to <b>May 26, 19 57</b> , that I last saw the deceased alive on <b>May 26, 19 57</b> , and that death occurred at <b>7:05 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>5/26/57</b> NATIONAL INSTITUTES OF HEALTH <b>Bethesda 14, Maryland</b>			
ACTUAL SIGNATURE <b>Richard J. Sanders</b> M.D.			
PHYSICIAN'S NAME (Type) <b>RICHARD J. SANDERS, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	22b. DATE THEREOF <b>5-31-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Southland Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. L. Chambers Co</b>		24a. REC'D BY REGISTRAR <b>5/29/57</b> 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 29 1957

BUREAU V. M.

05290

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taroma Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>700 Hudson Avenue</b>				d. STREET ADDRESS <b>120 Hesketh Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>L.</b> Last <b>COSTELLO</b>				4. DATE OF DEATH <b>May 22, 1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 22, 1870</b>	
9. AGE (In years last birthday) <b>87</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Patrick G. Nash</b>				14. MOTHER'S MAIDEN NAME <b>Annie Hughes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Walter J. Costello, (Same as # 2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute dilatation left Ventricle</b> DUE TO <b>Longestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arteriosclerosis of the Heart Disease</b> (c) <b>—</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Thrombosis, Chronic Pulmonary Emphysema, General Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>222</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>115C Jamieson St NW</b>	
20f. (City or town) <b>Washington, DC</b>				20g. (County) <b>—</b>		20h. (State) <b>—</b>	
21. I certify that I attended the deceased from <b>Sept. 4, 1947</b> to <b>May 22, 1957</b> , that I last saw the deceased alive on <b>May 20, 1957</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>115C Jamieson St NW</b> DATE SIGNED <b>William J. Collins</b> ACTUAL SIGNATURE <b>William J. Collins</b> M.D. <b>Washington, DC</b> PHYSICIAN'S NAME (Type) <b>—</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/24/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Fort Myer, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph G. Lewis, Inc.</b>				ADDRESS <b>1756 Pa. Ave., N.W.</b>		24a. REC'D BY REGISTRAR <b>5/24/57</b>	
24b. REGISTRAR'S SIGNATURE <b>—</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 27 1957

BUREAU V. B.

05339

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <u>GAITHERSBURG</u> <u>MONTGOMERY</u>			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>VA.</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u>			c. LENGTH OF STAY IN 1b <u>21 YRS</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ASBURY METHODIST HOME</u>			e. STREET ADDRESS <u>NONE</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>NETTIE</u> <u>L</u> <u>CREELE</u>			4. DATE OF DEATH Month Day Year <u>5</u> <u>29</u> <u>1957</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 5 1907</u>		9. AGE (In years last birthday) <u>82</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>LUCELIA F. CREELE</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>EDWARD H. CREELE</u>			14. MOTHER'S MAIDEN NAME <u>LUCELIA F. CREELE</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>ASBURY METHODIST HOME, GAITHERSBURG, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>DIABETES</u>					INTERVAL BETWEEN ONSET AND DEATH <u>One month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>10-24-1956</u> to <u>5-29-1957</u> , that I last saw the deceased alive on <u>5-27-1957</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Sarah E. Glover</u>			ADDRESS (Street, city or town, state) DATE SIGNED <u>4308 ANTHONY ST. NEWINGTON, MD 5-29-57</u>		
PHYSICIAN'S NAME (Type) <u>Dr. Sarah E. Glover</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-31-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Marshall Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Marshall. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg. Md.</u>			24a. REC'D BY REGISTRAR DATE <u>May 31-57</u>		
			24b. REGISTRAR'S SIGNATURE <u>Wanda L. Cooke</u>		

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: The form required that the death certificate be executed within 21 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 5 1957

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, see: *Birth, etc.*

05291

## CERTIFICATE OF DEATH

05306  
Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>		
c. LENGTH OF STAY IN 1b <u>11 hours 44 min</u>			d. STREET ADDRESS <u>1801 Newton, N. W.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Girl</u> Last <u>Davis</u>			4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1957</u>		
5. SEX <u>Girl</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>May 3, 1957</u>	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) yrs <u>11</u> Min. <u>44</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		
			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>Don Elroy Davis</u>			14. MOTHER'S MAIDEN NAME <u>Loretta Daisy <del>B</del> Ryder</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO (b) <u>Premature delivery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May 3</u> , 19 <u>57</u> , to <u>May 4</u> , 19 <u>57</u> that I last saw the deceased alive on <u>May 4</u> , 19 <u>57</u> , and that death occurred at <u>2:00 a.m.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>H. H. Diamond</u>		ADDRESS (Street, city or town, state) <u>8224-ga ave</u> DATE SIGNED <u>5/4/57</u>			
PHYSICIAN'S NAME (Type) <u>H. H. DIAMOND</u>					

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>5-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington San. &amp; Hosp.</u>	
				22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Montg. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Howard</u>				24a. REC'D BY REGISTRAR DATE <u>5/7/57</u>	
ADDRESS <u>Washington San. &amp; Hospital</u>				24b. REGISTRAR'S SIGNATURE <u>William Dodd</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V

MAY 2 1961

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**05292** Item 2. See: Birth Cert. et  
**CERTIFICATE OF DEATH**

**05307**

Reg. Dist. No. **223**

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>6 hours 4 min</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium and Hospital</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Md</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b> d. STREET ADDRESS <b>1801 Newton, N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Infant Girl Davis</b>				4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>19 57</b>			
5. SEX <b>Girl</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 3, 1957</b>	
9. AGE (in years last birthday) yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Don Elroy Davis</b>				14. MOTHER'S MAIDEN NAME <b>Loretta Daisy Ryder</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mother</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pre-maturity</b> <b>In complete pregnancy</b> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 3, 1957</b> to <b>May 3, 1957</b> that I last saw the deceased alive on <b>May 3, 1957</b> , and that death occurred at <b>8:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. H. Diamond</b>				ADDRESS (Street, city or town, state) <b>8224-ga ave S Md</b>			
PHYSICIAN'S NAME (Type) <b>H. H. DIAMOND</b>				DATE SIGNED <b>5/3/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>5-5-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium &amp; Hosp. Takoma Park, Montg. Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Hare, MD</b>				ADDRESS <b>Washington San. &amp; Hosp.</b>		24a. REC'D BY REGISTRAR <b>MAY 1957</b>	
						24b. REGISTRAR'S SIGNATURE <b>Edith and Park</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

MAY 7 1957

RECEIVED

05293

## CERTIFICATE OF DEATH

05308

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PR. GEO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SAN. + Hospital</b>		d. STREET ADDRESS <b>1413 EAST-WEST HWY.</b>	
3. NAME OF DECEASED (Type or print) <b>DELLINGER, NANCY SUE</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>8</b> Year <b>1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/27/57</b>
9. AGE (In years last birthday) yrs. <b>12</b> Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min <b>12</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>GARLAND DELLINGER</b>		14. MOTHER'S MAIDEN NAME <b>ALICE LEOILA MILLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>MOTHER</b>		Address <b>---</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital malformation of heart (interventricular septal defect)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>---</b> DUE TO <b>---</b> (c) <b>---</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congenital malformation of right kidney (hydronephrosis)</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>	
20c. TIME OF INJURY Month <b>May</b> Day <b>19</b> Year <b>1957</b> a.m. <b>---</b> p.m. <b>---</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>---</b>		20f. (City or town) <b>Hyattsville</b> (County) <b>MD</b> (State) <b>MD</b>	
21. I certify that I attended the deceased from <b>4/27</b> , 19 <b>57</b> , to <b>5/8</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5/8</b> , 19 <b>57</b> , and that death occurred at <b>9:20 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Repp Road Hyattsville, MD</b> DATE SIGNED <b>5/8/57</b>	
ACTUAL SIGNATURE <b>Joseph J. McDonald</b> M.D.		PHYSICIAN'S NAME (Type) <b>JOSEPH J. McDONALD, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>buried May 10, 1957</b>		22b. DATE THEREOF <b>May 10, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fishers Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Fishers Hill, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters</b> ADDRESS <b>254 Canal Street N.E.</b>		24a. REC'D BY REGISTRAR <b>---</b> DATE <b>5/8/57</b>	
24b. REGISTRAR'S SIGNATURE <b>---</b>		24c. REGISTRAR'S SIGNATURE <b>---</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 10 1957

BUREAU V. S.

05340

CERTIFICATE OF DEATH

Reg. Dist. No.

05309

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>1 Day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>926 "K" Street, N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Brooks Sheppard DENT</u>				4. DATE OF DEATH Month Day Year <u>May 9 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 Aug. 1887</u>		9. AGE (In years last birthday) <u>69</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy (Retired)</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Richard Dent</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Belle Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes 9-7-10 to 3-20-25</u>		16. SOCIAL SECURITY NO <u>578-12-3660</u>		17. INFORMANT Address <u>Bertie H. Smith, Brooke, Virginia</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease (undetermined)</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>± Adams-Stokes Syndrome</u> <u>6 hours</u> DUE TO (c) <u>+ Acute Congestive Heart Failure</u> <u>6 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REQUIRED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>404.1</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9 May</u> 19 <u>57</u> , to <u>9 May</u> 19 <u>57</u> , that I last saw the deceased alive on <u>9 May</u> 19 <u>57</u> , and that death occurred at <u>11:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Henry B. Karpinski</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>Henry B. Karpinski, LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>5-10-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>	

BUREAU V. B.

MAY 14 1957

RECEIVED



05341

## CERTIFICATE OF DEATH

Reg. Dist. No. 417

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>1 Hr. 40 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Navy Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>1000 ...</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Martha</u> Last <u>DICKSON</u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1900</u>	
9. AGE (In years last birthday) <u>1</u> yrs		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>		IF UNDER 24 HRS Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Richard Dixon</u>				14. MOTHER'S MAIDEN NAME <u>Robertson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT (Father) <u>Alfred R. Dickson</u> Address <u>...</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral Circulatory Collapse</u> 571.0 DUE TO <u>2 hours</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypernatremic Brain Damage</u> DUE TO <u>8 hours</u>							
(c) <u>Gastro enteritis</u> DUE TO <u>3 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10 May</u> 19 <u>57</u> , to <u>10 May</u> 19 <u>57</u> , that I last saw the deceased alive on <u>10 May</u> 19 <u>57</u> , and that death occurred at <u>7:10 A.M.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>J. H. Mazur</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md. 2-11-57</u>							
PHYSICIAN'S NAME (Type) <u>John H. Mazur, M.D., USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>14 MAY 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>...</u>				ADDRESS <u>...</u>		24a. REC'D BY REGISTRAR <u>...</u> DATE <u>...</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary E. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 15 1957

RECEIVED

05342		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		05311	
Item 21: G216 5-31-57L		CERTIFICATE OF DEATH		Reg. Dist. No. 216	
1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>		c. LENGTH OF STAY IN 1b <b>42 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>Box 94</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Deborah</b> Middle <b>Jean</b> Last <b>Dorsey</b>		4. DATE OF DEATH Month <b>May</b> Day <b>15</b> , Year <b>19 57</b>			
5 SEX <b>Female</b>	6 CO. OR RACE <b>Negro</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>February 12, 1956</b>	9 AGE (In years last birthday) <b>1</b> yrs	IF UNDER 1 YEAR: Months <b>1</b> Days <b>15</b> Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Asa Dorsey</b>		14. MOTHER'S MAIDEN NAME <b>Betty Simms</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16 SOCIAL SECURITY NO <b>None</b>		17 INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Lymph Leukemia 3 mo</b> DUE TO <b>Klebsiella Septicemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>E-Coli Septicemia</b> DUE TO (c) <b>2 weeks</b> <b>2 weeks</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>53.3</b>					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>50</b>	
20f (City or town) <b>Carroll Co., Maryland</b>		20g (County) <b>Carroll Co., Maryland</b>		20h (State) <b>Carroll Co., Maryland</b>	
21. I certify that I attended the deceased from <b>April 3, 1957</b> to <b>May 15, 1957</b> , that I last saw the deceased alive on <b>May 15, 1957</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Richard D. Fritz</b>		M.D. <b>The Clinical Center</b>		DATE SIGNED <b>5/15/57</b>	
PHYSICIAN'S NAME (Type) <b>Richard D. Fritz, M.D.</b>		<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b DATE THEREOF <b>5-17-1957</b>	22c NAME OF CEMETERY OR CREMATOR <b>Fairview</b>		22d LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Maryland</b>		24a REC'D BY REGISTRAR DATE <b>MAY 17 '57</b>	
				24b REGISTRAR'S SIGNATURE <b>Bessie Thompson</b>	

BUREAU V. A.

MAY 17 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

05343

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05312

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>				d. STREET ADDRESS <b>RFD # 3</b>			
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Dorsey</b> Last <b></b>				4. DATE OF DEATH Month <b>May</b> Day <b>31</b> , Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/13/1905</b>		9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>Howard Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>James W. Dorsey</b>				14. MOTHER'S MAIDEN NAME <b>Louisa Hopkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT Address <b>Lily Anderson, Glenwood, Howard Co., Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>May 31, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/4/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bush Park,</b>		22d. LOCATION (City, town, or county) (State) <b>Cookesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>				ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 6 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Louise Thompson</b>			

BUREAU V. S.

JUN 6 1957

RECEIVED

05344

## CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			
c. LENGTH OF STAY IN 1b <b>20 yrs.</b>							
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <b>9405 WORTH AVENUE</b>				d. STREET ADDRESS <b>9405 WORTH AVENUE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>FRANCES</b> Last <b>DOVE</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>26</b> Year <b>19 57</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 10, 1880</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>RICHARD H. W. REED</b>				14. MOTHER'S MAIDEN NAME <b>ELLA F. HEPBURN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Mr. George W. Dove, 9405 Worth Ave. Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> <b>143X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>20 YRS.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 WKS.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>331X</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>OCTOBER, 1954</b> , to <b>MAY 26, 1957</b> , that I last saw the deceased alive on <b>MAY 26, 1957</b> , and that death occurred at <b>4<sup>20</sup> P. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James R. Coleman MD</b>				ADDRESS (Street, city or town, state) <b>113 CARROLL ST NW WASHINGTON 12 D.C.</b>			
DATE SIGNED <b>5/26/57</b>							
PHYSICIAN'S NAME (Type) <b>JAMES R. COLEMAN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/29/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. B. Thompson</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>5/31/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Francis J. [Signature]</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

22

RECEIVED  
JUN 6 1957  
BUREAU V. S.



05345

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>22d</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Silver Spring</u>		TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
		<u>10117 Kenross Rd.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print)	(First) (Middle) (Last)	OF DEATH:	
<u>CHRISTINA</u>	<u>DRAEGER</u>	<u>May 7</u>	<u>1957</u>
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>8, 1872</u>
			9. AGE last birthday: <u>84</u> yrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>	
11. BIRTHPLACE (State or foreign country): <u>22d</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Dietrich Draeger</u>		14. MOTHER'S MAIDEN NAME: <u>Maria C. Mensing</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <u>Gertrude Rowley 10117 Kenross Rd.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE		(A) <u>Terminal Bronchial pneumonia</u>	
ANTECEDENT CAUSE (S)		DUE TO <u>Cardio-Vascular Renal Disease</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(B) <u>Arterio-sclerosis</u>	
		(C)	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>4-5</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/5, 1957</u> to <u>5/7, 1957</u> , that I last saw the deceased alive on <u>5/6, 1957</u> , and that death occurred at <u>12:00 P.M.</u> from the causes and on the date stated above.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>May 9, 1957</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>North Creek</u>		<u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>5/15/57</u>		<u>James Potter</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Real Funeral Home</u>		<u>4812 So. Ave. NW</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

MAY 21 1957

RECEIVED

05346

## CERTIFICATE OF DEATH

Reg. Dist. No

216

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>				c. LENGTH OF STAY IN 1b <b>15 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Russell</b> Middle <b>Alton</b> Last <b>Dudderar</b>				4. DATE OF DEATH Month <b>May</b> Day <b>4</b> Year <b>19 57</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>April 17, 1892</b>	9 AGE (In years last birthday) <b>65</b> yes	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Director (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>D. Alton Dudderar</b>				14. MOTHER'S MAIDEN NAME <b>Myra L. Ecker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> <b>WWI</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>359-03-6484</b>	17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anuria &amp; uremia, Bronchopneumonia</b> DUE TO <b>Massive Gastric Intestinal Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hodgkins Disease - abdominal</b> DUE TO (c) <b>also - Left Subclinal Hemorrhage</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis - severe</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>April 19</b> , 19 <b>57</b> , to <b>May 4</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 4</b> , 19 <b>57</b> , and that death occurred at <b>1:30 p.m.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>5-4-57</b>							
ACTUAL SIGNATURE <b>Chester Z. Haverback</b> M.D. <b>National Institutes of Health</b>							
PHYSICIAN'S NAME (Type) <b>Chester Z. Haverback, M. D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 7-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Linganore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Unionville- Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b> W.			ADDRESS <b>Frederick-Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>7 May 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Beatrix Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please give carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
MAY 8 1957  
BUREAU V. S.

05347

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney md</u>		c. LENGTH OF STAY IN 1b <u>20 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY CHILDS</u> First Middle Last		4. DATE OF DEATH <u>MAY</u> Month Day Year <u>23</u> <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 28 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Childs</u>		14. MOTHER'S MAIDEN NAME <u>Octavia Owen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>2</u>	
17. INFORMANT <u>Elma R Duley Deerevols</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Left Breast</u> <u>170X</u> DUE TO <u>Metastases chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 yr</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/6/</u> 19 <u>57</u> to <u>5/23/</u> 19 <u>57</u> that I last saw the deceased alive on <u>5/23/</u> 19 <u>57</u> , and that death occurred at <u>2 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>5/23/57</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>		M.D. <u>[Signature]</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 24</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	22d. LOCATION (City, town, or county) (State) <u>Olney md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Royce Barber</u> ADDRESS <u>Laytonville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5/28/57</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. B.

AY 31 1957

RECEIVED

05294

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN TB <i>3 days</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium d. Hosp.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <i>D.C.</i> b. COUNTY <i>D.C.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wash. D.C.</i> d. STREET ADDRESS <i>712-19th St. N.W.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle (Last) <i>Mrs. Linche (Euphonia)</i>		4. DATE OF DEATH Month Day Year <i>5 29 1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Chinese</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/15/05</i>
9. AGE (In years last birthday) <i>51</i> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>China</i>	
11. BIRTHPLACE (State or foreign country) <i>China</i>		12. CITIZEN OF WHAT COUNTRY? <i>China</i>	
13. FATHER'S NAME <i>Swang Lee</i>		14. MOTHER'S MAIDEN NAME <i>Manee Kim</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO <i>—</i>	
17. INFORMANT <i>Daughter</i>		Address <i>Wash. D.C. 712-19th St. N.W.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO <i>Arteriosclerotic cardiovascular disease</i> DUE TO <i>Thyroid storm postop thyroidectomy</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>2.1</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov 1957</i> to <i>May 29 1957</i> that I last saw the deceased alive on <i>May 29 1957</i> , and that death occurred at <i>2:50 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. Allen Wall</i>		ADDRESS (Street, city or town, state) <i>1414 Underwood St. N.W. D.C.</i>	
PHYSICIAN'S NAME (Type) <i>C. ALLEN WALL</i>		DATE SIGNED <i>5/29/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>June 1, 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>	22d. LOCATION (City, town, or county) (State) <i>Prince George County, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		24. REC'D BY REGISTRAR <i>5/29/57</i>	24b. REGISTRAR'S SIGNATURE <i>J. Arthur Walters</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 10 1957

RECEIVED



05348

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>171200 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>11200 Prospect Ave</u>			
3. NAME OF DECEASED (Type or print) <u>William W Eastman</u>				DATE OF DEATH <u>MAY 31 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 11-1886</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MASTER RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SD. DENTIST</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	
13. FATHER'S NAME <u>Nathaniel A Eastman</u>				14. MOTHER'S MAIDEN NAME <u>ALMIRA ANN Fairchild</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>W. W. Eastman, M.D. (same as #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dry Gangrene left leg + Toxemia</u> 4 .1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Far advanced art. Sclerosis Gen</u> DUE TO (c) <u>Senility + Debility</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>15 yrs</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>DEC 1955</u> to <u>May 1957</u> , that I last saw the deceased alive on <u>20 May 1957</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John B. Ziegler</u> M.D.				ADDRESS (Street, city or town, state) <u>Alney, Md</u>			
DATE SIGNED <u>May 31 1957</u>				DATE SIGNED <u>May 31 1957</u>			
PHYSICIAN'S NAME (Type) <u>J. B. ZIEGLER</u>				PHYSICIAN'S NAME (Type) <u>J. B. ZIEGLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>May 31 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GERTRUDE WASHINGTON CEM</u>		22d. LOCATION (City, town, or county) (State) <u>RIGGS RD. HARTSDALE, PG. Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Ziegler</u>				ADDRESS <u>12 DC 254 CARRILL ST NW</u>		24a. REC'D BY REGISTRAR <u>Gertrude Lawler</u>	
DATE <u>5/31/57</u>				24b. REGISTRAR'S SIGNATURE <u>Gertrude Lawler</u>		DATE <u>5/31/57</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957

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will be  
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*[Faint handwritten notes at the bottom of the page]*

05349

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodfield</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodfield</b>	
c. LENGTH OF STAY IN 1b <b>3 years</b>		d. STREET ADDRESS <b>R.F.D. Gaithersburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. Gaithersburg</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary I. Fallon</b>		4. DATE OF DEATH Month Day Year <b>May 24 19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 6, 1872</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Straw Hat Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John C. Fallon</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Fallon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>212-05-90614</b>	
17. INFORMANT <b>Mr. Wm. J. Mathers, Gaithersburg, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anteroseptal cardiovascular disease</b> <b>4 2.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause lost. (b) _____ (c) _____ DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 20, 1957</b> to <b>May 29, 1957</b> , that I last saw the deceased alive on <b>May 21, 1957</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>Damascus, Md.</b>		DATE SIGNED <b>May 24-57</b>	
ACTUAL SIGNATURE <b>James P. Kerr</b> M.D.			
PHYSICIAN'S NAME (Type) <b>James P. Kerr, M.D.</b>		<b>Damascus, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 27, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	22d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James P. Kerr</b> ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR <b>May 25, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>W. J. Mathers</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 1957

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## 05295 CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hosp.</u>				d. STREET ADDRESS <u>1709-Dennis Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Eugene</u> Middle <u>George</u> Last <u>Fasenmyer</u>				4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-27-87</u>	
9. AGE (In years last birthday) <u>68</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>weigh master</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>State Grain Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Amer. U.S.A.</u>							
13. FATHER'S NAME <u>Anthony Fasenmyer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Sterner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>487-09-5642</u>		17. INFORMANT <u>Washington San &amp; Hosp Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>							
DUE TO <u>Coronary Thrombosis</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular disease</u>							
DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u> <u>72 hrs</u> <u>years</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>May 24, 1957</u> to <u>May 25, 1957</u> , that I last saw the deceased alive on <u>May 22, 1957</u> , and that death occurred at <u>2:22 PM</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Philip E. Jones</u> M.D. <u>918 Chisworth St. N.W.</u>				DATE SIGNED <u>5-26-57</u>			
PHYSICIAN'S NAME (Type) <u>PHILIP E. JONES</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William E. Thompson</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>JUN 9 - 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Philip E. Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 10 1957

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## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>				c. LENGTH OF STAY IN 1b <b>122 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Vashti</b> Middle <b>Dorthea</b> Last <b>Fauntroy</b>				4. DATE OF DEATH Month <b>May</b> Day <b>8,</b> Year <b>1957</b>			
5 SEX <b>Female</b>		6 COLOR OR RACE <b>Negro</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>March 24, 1911</b>	
9 AGE (In years last birthday) <b>46</b> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sewing Machine Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>		11 BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13 FATHER'S NAME <b>David S. Hooper</b>				14 MOTHER'S MAIDEN NAME <b>Lena Ford</b>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16 SOCIAL SECURITY NO <b>125-16-6326</b>		17 INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>195X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>metastatic adrenal carcinoma</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>yes.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month Day, Year Hour a m p m 19				20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>January 6, 1957</b> , to <b>May 8, 1957</b> , that I last saw the deceased alive on <b>May 8, 1957</b> , and that death occurred at <b>10:05 AM</b> , from the causes and on the date stated above							
ADDRESS (Street, city or town, state) <b>The Clinical Center</b>				DATE SIGNED <b>5/9/57</b>			
ACTUAL SIGNATURE <b>Sherman Weissman, M.D.</b>							
PHYSICIAN'S NAME (Type) <b>Sherman Weissman, M.D.</b>				<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b DATE THEREOF <b>5-15-57</b>		22c NAME OF CEMETERY OR CREMATORY <b>Eden Cemetery</b>		22d LOCATION (City, town, or county) (State) <b>Darby, Delaware Co., Pa.</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>John T. Rhines &amp; Co.</b>				ADDRESS <b>901 3rd St., S. W.</b>		24a REC'D BY REGISTRAR DATE <b>6/12/57</b>	
				24b REGISTRAR'S SIGNATURE <b>Walter E. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 21

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05320  
05298 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 123

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>20 yrs</u>		d. STREET ADDRESS <u>103 Sheridan Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>103 Sheridan Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Feltman</u>		4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-14-1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Club</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Was Dept</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm Feltman</u>		14. MOTHER'S MAIDEN NAME <u>Robina Beattie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>110 441 777</u>	
17. INFORMANT <u>110 441 777</u>		Address <u>22 1/2 1st St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary atherosclerosis</u> 15 yr		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>15 yr</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-22-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/25/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		ADDRESS <u>2901 14th St., N.W.</u>	
24a. REC'D BY REGISTRAR <u>3/23/57</u>		24b. REGISTRAR'S SIGNATURE <u>Robert D. Add</u>	

BUREAU V. S.

MAY 3 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05321

05351

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alta Vista</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alta Vista</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5525 Charles Street</u>				d. STREET ADDRESS <u>5525 Charles Street</u>			
3 NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>L.</u> Last <u>Foster</u>				4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1957</u>			
5 SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 5, 1864</u>	9. AGE (In years last birthday) <u>92</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>7</u>		IF OVER 24 HRS Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12 CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Charles Clinton</u>				14. MOTHER'S MAIDEN NAME <u>Frances A. Ireland</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs John A. Dickinson- Item# 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>400.0</u>						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. <u>19</u> p. <u>m.</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		
			20f. (City or town) <u></u>		(County) <u></u>		
			(State) <u></u>				
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>50</u> , to <u>May 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 12</u> , 19 <u>57</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>George Sharpe</u> M.D.							
PHYSICIAN'S NAME (Type) <u>George Sharpe M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>5/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>5-14-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

BUREAU V. B.

W 16 1957

RECEIVED

05352

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>✓</u>		d. STREET ADDRESS <u>Rural</u>	
3. NAME OF DECEASED (Type or print) <u>Idella</u> First <u>Frize</u> Last		4. DATE OF DEATH <u>May-13-1957</u> Month <u>May</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-6-1884</u>
9. AGE (In years last birthday) <u>73</u> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>10</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-keeping at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gaithersburg, Md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Reed</u>		14. MOTHER'S MAIDEN NAME <u>Delby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or just home) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mary E. Donaldson, 1927 U.P. No. 8. E. D. C.</u>	
17. INFORMANT <u>Mary E. Donaldson, 1927 U.P. No. 8. E. D. C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 year +</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct-10-1945</u> , to <u>May-13-1957</u> , that I last saw the deceased alive on <u>May-13-1957</u> , and that death occurred on <u>May-13-1957</u> at <u>11:30 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Miller</u> M.D.		ADDRESS (Street, city or town, state) <u>7-Brooks Ave</u>	
PHYSICIAN'S NAME (Type) <u>W. C. MILLER, M.D.</u>		Gaithersburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-16-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	22d. LOCAT ON (City, town, or county) (State) <u>Gaithersburg Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Garton, Gaithersburg, Md</u>		24a. REC'D BY REGISTRAR <u>Abner J. Cook</u>	
ADDRESS <u>Gaithersburg, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Abner J. Cook</u>	
DATE <u>May 16, 57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

APR 20 1957

RECEIVED

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05323	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 216	
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Herndon</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6622 Braeburn Parkway</b>					d. STREET ADDRESS <b>Route #2</b>					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Stanley</b> Middle <b>Richard</b> Last <b>GARDNER</b>					4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>19 57</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 26, 1882</b>		9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>		11. BIRTHPLACE (State or foreign country) <b>London, England</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA (Nat.)</b>			
13. FATHER'S NAME <b>Charles Gardner</b>					14. MOTHER'S MAIDEN NAME <b>Emily Jane Unknown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Fred Gardner -- Item # 2</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>History of previous attacks</b>										INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <b>May 6, 1957</b>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/9/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arnon Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Forrestville Fairfax Va.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey #7557 Wis. Ave. Bethesda Md</b>						24a. REC'D BY REGISTRAR <b>5-7-57</b>		24b. REGISTRAR'S SIGNATURE <b>James M. Thompson</b>			

RECEIVED

JAN 9 1957

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 See: Birth cert. et

05354

## CERTIFICATE OF DEATH

05324

Reg. Dist. No.

213

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> c. LENGTH OF STAY IN 1b				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>5600 - 16th Avenue, Apt. # 2</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <u>Infant Boy Geer</u>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>6</u> Year <u>1957</u>				
5. SEX <u>Boy</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 6, 1957</u>		
9. AGE (In years last birthday) yrs. <u>2</u>		10. UNDER 1 YEAR Months <u>2</u> Days <u>5</u>		11. UNDER 24 HRS. Hours <u>2</u> Min. <u>5</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>Howard Stark Geer, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Charmion Paulette Cheanault</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Failure to Establish Respiration</u> DUE TO <u>Probable - Tracheal Stenosis/Atresia</u> (b) <u>10</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity, Web Neck, Malformed Ears - Clubfoot - Rt.</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>May 6, 1957</u> to <u>May 6, 1957</u> that I last saw the deceased alive on <u>May 6, 1957</u> , and that death occurred at <u>12:50 PM</u> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>Ralph Steller</u> M.D. <u>931 Pershing Dr. - S.S.</u>				ADDRESS (Street, city or town, state) DATE SIGNED				
PHYSICIAN'S NAME (Type) <u>Ralph Steller, M.D.</u>				<u>931 Pershing Dr., Silver Spring, Md.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Crementation</u>		22b. DATE THEREOF <u>5-9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium &amp; Hosp, Takoma Park, Montg. Md.</u>		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. [unclear]</u> ADDRESS <u>Wash. San. &amp; Hospital</u>				24a. REC'D BY REGISTRAR DATE <u>5/11/57</u>		24b. REGISTRAR'S SIGNATURE <u>[unclear]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 05355 CERTIFICATE OF DEATH

05325 214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12009 Milton Street</b>		d. STREET ADDRESS <b>12009 Milton Street</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>George</b> Last <b>Georgopoulos</b>		4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 15, 1892</b>
9. AGE (In years last birthday) <b>64</b> yrs		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Florist</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Greece</b>		12. CITIZEN OF WHAT COUNTRY? <b>Greece</b> ✓	
13. FATHER'S NAME <b>George Georgopoulos</b>		14. MOTHER'S MAIDEN NAME <b>Pagona Economos</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>577-48-1463</b>	
17. INFORMANT <b>wife</b> Address <b>Anna Georgopoulos 12009 Milton St. SS, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb 15</b> , 19 <b>57</b> , to <b>May 27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Feb 15</b> , 19 <b>57</b> , and that death occurred at <b>3:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10620 Leverage Ave, Silver Spring, Md.</b> DATE SIGNED <b>May 27, 1957</b>			
ACTUAL SIGNATURE <b>Michael R. Oshutz</b> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, or other disposition <b>burial</b>	22b. DATE THEREOF <b>5/29/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Pr. Geo. Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.</b>		24. RECEIVED BY REGISTRAR <b>MAY 29 1957</b>	24b. REGISTRAR'S SIGNATURE

RECEIVED

MAY 28 1951

BUREAU V. S.

## 05297 CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>II Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>823 Gist Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Reuben</b>		Middle <b>A (int. only)</b>		Last <b>Goldstein</b>		4. DATE OF DEATH Month <b>May</b>		Day <b>9</b>		Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-15-85</b>		9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>24</b>		IF UNDER 24 HRS Days <b>at least 4</b>		Hours <b>4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired.</b>				11. BIRTHPLACE (State or foreign country) <b>Poland</b>				12. CITIZEN OF WHAT COUNTRY? <b>America</b>			
13. FATHER'S NAME <b>Jacob Goldstein</b>						14. MOTHER'S MAIDEN NAME <b>Devera (unknown)</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>				16. SOCIAL SECURITY NO <b>-----</b>				17. INFORMANT <b>Hospital Records</b>				Address			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>												<b>24 hours</b>			
420.0 DUE TO												<b>at least 4 years</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
(b) <b>Arteriosclerotic heart disease</b>															
(c) <b>Hypertensive Cardiovascular Renal Disease</b>												<b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	

21. I certify that I attended the deceased from <b>Jan 9</b> , 1953, to <b>May 9</b> , 1957, that I last saw the deceased alive on <b>May 8</b> , 1957, and that death occurred at <b>6:18 A. M.</b> from the causes and on the date stated above													
ADDRESS (Street, city or town, state) <b>8237 Georgia Ave Silver Spring Md</b>										DATE SIGNED <b>May 9, 1957</b>			
ACTUAL SIGNATURE <b>Clara H. Trauman</b> M.D.													
PHYSICIAN'S NAME (Type) <b>Clara H. Trauman</b>													

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-10-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Myra Israel</b>		22d. LOCATION (City, town or county) <b>Balto</b>		(State) <b>Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis</b>						ADDRESS <b>2100 Centaro Pl</b>		24. REC'D BY REGISTRAR <b>MAY 10 1957</b>		25. REGISTRAR'S SIGNATURE <b>J. H. H. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 10 1957

RECEIVED

## 05356 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Fairborn</b>	
c. LENGTH OF STAY IN 1b <b>51 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>120 James Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>Evelyn</b> Middle <b>Mary</b> Last <b>Gundlach</b>		4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>1957</b>			
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 18, 1911</b>	9. AGE (In years last birthday) <b>46 yrs</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dietician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
13. FATHER'S NAME <b>Henry Sessions</b>		14. MOTHER'S MAIDEN NAME <b>Mary Carlin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ca of stomach &amp; metastases to abd., thoracic, &amp; cerebral nodes. Congested (R) foot secondary to</b> DUE TO <b>(b) massive venous occlusion.</b> DUE TO <b>(c) multiple pulmonary infarcts</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(c) multiple renal infarcts</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>March 11</b> , 19 <b>57</b> , to <b>May 1</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 1</b> , 19 <b>57</b> , and that death occurred at <b>2:35 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <b>Peter D. Olch</b>		M.D. <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Peter D. Olch, M. D.</b>					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Bur.-Transit</b>	22b. DATE THEREOF <b>4/2/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Josephs</b>	22d. LOCATION (City, town or county)	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>5-3-57</b>	24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
MAY 6 1957  
BUREAU V. S.



05328

## MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55

RECEIVED

MAY 3 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05358

CERTIFICATE OF DEATH

05329

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>6 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Clement Lane, Springbrook Forest</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edward E. Hansler</b>		4. DATE OF DEATH <b>May 18 19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 10, 1875</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-employed (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Meat Dealer</b>	
11. BIRTHPLACE (State or foreign country) <b>New York, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Hansler</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Dear</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Wesley S. Meginn, Clement Lane, Silver Spring</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>101</b> DUE TO <b>Cancer of Stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>9 months</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4</b> <b>Generalized Arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 5, 1954</b> to <b>May 18, 1957</b> that I last saw the deceased alive on <b>May 18, 1957</b> and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John J. Curry</b> M.D.		ADDRESS (Street, city or town, state) <b>10620 Georgian Ave Silver Spring, Md</b>	
DATE SIGNED <b>5/21/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 21, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Orange County, New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Humphrey</b>		ADDRESS <b>Silver Spring, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 5/21/57</b>		24b. REGISTRAR'S SIGNATURE <b>Frances Carter</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. AIR FORCE

1957

RECEIVED

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>10 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY	
3. NAME OF DECEASED (Type or print) <b>Rose</b> First <b>(None)</b> Middle <b>Harbanoff</b> Last 4. DATE OF DEATH <b>May 1, 1957</b> Month <b>May</b> Day <b>1</b> Year <b>1957</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>August 22, 1909</b> 9. AGE (In years or birthday) <b>47</b> yrs F UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b> 11. BIRTHPLACE (State or foreign country) <b>New York</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Abraham Harbanoff</b> 14. MOTHER'S MAIDEN NAME <b>Sophie Shatkin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO <b>110-03-4881</b> 17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular arrhythmic and cardiac arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Combined aortic and mitral regurgitation</b> DUE TO (c) <b>Calcific aortic and mitral stenosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>17 hrs.</b> <b>17 hrs.</b> <b>43 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 21</b> , 19 <b>57</b> , to <b>May 1</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 1</b> , 19 <b>57</b> , and that death occurred at <b>5:20 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b> DATE SIGNED <b>5/1/57</b>			
ACTUAL SIGNATURE <b>R. Robinson Baker</b> PHYSICIAN'S NAME (Type) <b>R. Robinson Baker, M. D.</b>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>5/2-57</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Burien de Harish Cem.</b> 22d. LOCATION (City, town, or county) (State) <b>Staten Island NY</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Goldberg Funeral Home</b> ADDRESS <b>4217 G.H. Street</b> 24a. REC'D BY REGISTRAR <b>6-57</b> 24b. REGISTRAR'S SIGNATURE <b>12-11-57</b>			

RECEIVED

MAY 7 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 05360 CERTIFICATE OF DEATH

05331

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Germantown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPHINE</b> Middle <b>HARDING</b> Last <b>HARDING</b>		4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>19 57</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1869</b>
9. AGE (In years last birthday) <b>88</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Ethel Martin, Cabin Johns, Md. (granddaughter)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>abdominal carcinomatosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>47.0 Arteriosclerosis, Cachexia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5 December 1946</b> to <b>25 May, 1957</b> , that I last saw the deceased alive on <b>25 May, 1957</b> , and that death occurred at <b>2 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John G. Fawcett</b>		M.D. <b>Boyd, Maryland, 27 May 57</b>	
PHYSICIAN'S NAME (Type) <b>JOHN G. FAWCETT</b>		ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/30/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Brownstown</b>		22d. LOCATION (City, town, or county) (State) <b>Germantown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Purdie</b>		ADDRESS <b>Rockville, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 3 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Lester Thompson</b>	

RECEIVED

JUN 3 1957

BUREAU V. 2



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05361

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Md.</u>			
c. LENGTH OF STAY IN 1b <u>2 hours</u>				d. STREET ADDRESS <u>2611-PARKER AVE.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY, M. HARTMAN</u>				4. DATE OF DEATH <u>MAY 23 1951</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 10 - 89</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>23</u> Days <u>23</u>		IF UNDER 24 HRS. Hours <u>19</u> Min <u>51</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA Philadelphia U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Cunliffe</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>MRS Gladys Rucini (Daughter)</u>				Address <u>Above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO <u>myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>NOV 23 1950</u> to <u>23 May 1951</u> that I last saw the deceased alive on <u>23 May 1951</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11602 Georgia Ave Silver Spring Maryland</u>							
ACTUAL SIGNATURE <u>Morris Perry</u> M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>MORRIS PERRY</u>							
22a. BURIAL, CREMATION, TRANSFER, & BURIAL <u>5/27/51</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>FERNWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>UPPER DARBY, PENNSYLVANIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner S. Kungshing</u> ADDRESS <u>8454 So. Ave</u>				24a. REC'D BY REGISTRAR <u>DATE 5-28-51</u>		24b. REGISTRAR'S SIGNATURE <u>Bea M. Thompson</u>	

RECEIVED

MAY 31 1957

BUREAU V. S.

05362 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Montgomery</b>	
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c LENGTH OF STAY IN 1b <b>12 days</b>	
d NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>	
f STREET ADDRESS <b>#5 Tulip Avenue</b>		g IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Everett</b> Middle <b>West</b> Last <b>Hawkins</b>		4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>57</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>March 1, 1888</b>
9 AGE (in years last birthday) <b>69</b> yrs.		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Charles Hawkins</b>		14 MOTHER'S M A DEN NAME <b>Julia Pope</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <b>unknown</b>	
17 INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18 CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia, Pneumonia</b> <b>204.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Lymphocytic Leukemia</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>473.1</b>			INTERVAL BETWEEN ONSET AND DEATH
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a m. p. m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 19, 1957</b> , to <b>May 1, 1957</b> , that I last saw the deceased alive on <b>May 1, 1957</b> , and that death occurred at <b>2:15 A M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James R. Jude</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
DATE SIGNED			
22a BURIAL, CREMATON, REMOVAL (Specify) <b>BURIAL</b>		22b DATE THEREOF <b>MAY 4 1957</b>	
22c NAME OF CEMETERY OR CREMATORY <b>BROOK GROVE Park Lawn</b>		22d LOCATION (City, town, or county) (State) <b>Montgomery &amp; Schville MD</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>ROY W. BARBER</b>		ADDRESS <b>LAYTONSVILLE MD</b>	
24a REC'D BY REGISTRAR <b>DATE 5-7-57</b>		24b REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 9 1957

BUREAU V. S.

05363

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05334

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH a. STREET ADDRESS MONTGOMERY Co. 12116 Ba An		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Maryland b. COUNTY Montgomery c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wheaton Md. d. STREET ADDRESS (If rural, give location) Arlow	
b. FULL NAME OF HOSPITAL OR INSTITUTION Wilhelmina Heinzelung (At home)		c. LENGTH OF STAY IN HOSPITAL IN D. C.	
3. NAME OF DECEASED (Type or Print) a. (First) Wilhelmina b. (Middle) -- c. (Last) Heinzelung		4. DATE OF DEATH (Month) (Day) (Year) May 10 - 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH 81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11b. CITIZEN OF WHAT COUNTRY? USA		11a. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Ludwig Benner		14. MOTHER'S MAIDEN NAME Catherine Sartor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17a. INFORMANT Lillian Cress		17b. RELATED TO DECEDENT AS Daughter	
18. MEDICAL CERTIFICATION Enter only one cause per line for (a), (b), and (c) FINAL DISEASE OR CONDITION PRECEDING DEATH I. ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the cause (a) stating the underlying cause last. DUE TO (a) Cancer of Gall Bladder DUE TO (b) with abdominal metastases DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 months
OTHER SIGNIFICANT CONDITIONS II. Conditions contributing to the death but not related to the disease or condition causing death (Include report of pregnancy within 3 months of death). 450 Arterio Sclerosis			years
19a. DATE OF OPERATION 4/10/57	19b. MAJOR FINDINGS OF OPERATION Cancer of Gall Bladder	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. AUTOPSY FINDINGS
22. I hereby certify that I attended the deceased from April 23, 1957, to May 10, 1957, and last seen alive on May 10, 1957, and that death occurred at 2:50 AM from the causes and on the date stated above.			
23a. SIGNATURE John J. Curry M. D.		23b. ADDRESS 10620 Glacig-Rue Bellevue, Ohio	23c. DATE SIGNED 5/10/57
24a. BURIAL, CREMATION, OR REMOVAL <input type="checkbox"/>	24b. DATE 5-13-57	24c. NAME OF CEMETERY OR CREMATORY Lakewood Memorial Park	24d. LOCATION (City, town, or county) (State) Toledo, Ohio
25a. Undertaker's Registration Number 335		25b. UNDERTAKER Frank Jan	
		25c. ADDRESS 5406 Del. Ave NW D.C.	

BUREAU V. 3

JAN 21 1957

RECEIVED

05364

## CERTIFICATE OF DEATH

05335

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. STREET ADDRESS <b>208 Forrest Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Hamilton</b> Last <b>Higgins</b>				4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1890</b>	9. AGE (In years last birthday) <b>66 yrs</b>	F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner of Oil Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oil Company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Higgins</b>				14. MOTHER'S MAIDEN NAME <b>Roberta Baker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NUMBER <b>088-07-1128</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary congestion</b>							
411X DUE TO (b) <b>Arteriosclerosis</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Rheumatic fever &amp; heart disease</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 day</b> <b>8+ yrs</b> <b>50+ yrs</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 26, 1957</b> to <b>May 26, 1957</b> , that I last saw the deceased alive on <b>May 26, 1957</b> , and that death occurred at <b>10:20 P</b> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>The Clinical Center</b>				DATE SIGNED <b>5/27/57</b>			
ACTUAL SIGNATURE <b>Emery C. Herman, Jr.</b> M.D.				NATIONAL INSTITUTES OF HEALTH <b>Bethesda 14, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Emery C. Herman, Jr.</b>							
22a. BURIAL, CREMATION, REMAINS (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/29/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		22d. LOCATION (City, town, or county) (State) <b>Gaithersburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>5-28-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

AY 31 1957

RECEIVED



05365

## CERTIFICATE OF DEATH

05336

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>North Carolina</b> b. COUNTY <b>Buncombe</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	c. LENGTH OF STAY IN 1b <b>6 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Naval Hospital, NNM, Bethesda, Md.</b>		d. STREET ADDRESS <b>910 Magnolia</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Walter Robert HINTON Jr.</b>		4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-10-09</b>
9. AGE (In years last birthday) <b>47 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dentist</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Walter Hinton</b>	
14. MOTHER'S MAIDEN NAME <b>Anne Hinton</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>yes</b> (If yes, give war or dates of service) <b>1953-55</b>	
16. SOCIAL SECURITY NO		17. INFORMANT <b>G.W. Taylor M.D.</b> Address <b>U.S.N.H. Bethesda, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intrabronchial hemorrhage</b> <b>162 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>carcinoma of trachea and main bronchi</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5-22-57</b> , 19____, to <b>5-28-57</b> , 19____, that I last saw the deceased alive on <b>5-28-57</b> , 19____, and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>George Winston Taylor</b> M.D.		U. S. Naval Hospital, Bethesda, Md <b>5-28</b>	
PHYSICIAN'S NAME (Type) <b>George Winston Taylor M.D.</b>		U. S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3 June 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Buffalo Prebsyterian Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Greensboro, North Carolina</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chambers, 3072 "M" St., NW, Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE 5-29-57</b>	24b. REGISTRAR'S SIGNATURE <b>Mary E. Parrelly</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 31 1957

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05366

CERTIFICATE OF DEATH

Reg. Dist. No. 216

05337

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1 City 13</u>	
3. NAME OF DECEASED (Type or print) <u>William Alexander Howard</u>		4. DATE OF DEATH <u>May 7 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5/57</u>
9. AGE (In years last birthday) yrs. <u>60</u>		IF UNDER 1 YEAR: Months <u>2</u> Days <u>2</u> Hours <u>24</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTH PLACE (State or foreign country) <u>Bethesda, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Norman Martin Howard</u>		14. MOTHER'S MAIDEN NAME <u>Bettie Zane Bynatter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mother</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity with</u> DUE TO <u>partial atelectasis of lungs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGENITAL ABSENCE OF ONE KIDNEY</u> (c) <u>HYDRONEPHROSIS OF KIDNEY &amp; BLADDER</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 5, 1957</u> to <u>May 7, 1957</u> , that I last saw the deceased alive on <u>May 7, 1957</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William G. Hall, M.D.</u>		ADDRESS (Street, city or town, state) <u>615 W. Montgomery Ave. Rockville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>William G. Hall, M.D.</u>		DATE SIGNED <u>5-8-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/9/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>5-10-57</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 21

12 1957

RECEIVED

05367

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN It <b>38 days</b>			
d. NAME OF HOSPITAL (If not in hospital, the street address of the institution) <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>				e. STREET ADDRESS <b>6000 North 19th Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Valton</b> Middle <b>Estes</b> Last <b>Huffman</b>				4. DATE OF DEATH Month <b>May</b> Day <b>8,</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3 January 1909</b>	
9. AGE (In years last birthday) <b>48</b> yrs		IF UNDER 1 YEAR Months <b>4</b> Days <b>8</b> Hours <b>15</b> Min.		IF UNDER 24 HRS Months <b>4</b> Days <b>8</b> Hours <b>15</b> Min.		10. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Robert E. Short</b>			
14. MOTHER'S MAIDEN NAME <b>Laura Dadisman</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service.) <b>No</b>			
16. SOCIAL SECURITY NO. <b>578-03-1480</b>				17. INFORMANT <b>The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma - Rt + left lungs</b> DUE TO <b>metastatic carcinoma to pericardium - increased intracranial pressure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>carcinoma primary of mammary gland</b> DUE TO (c) <b>carcinoma primary of mammary gland</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1, 19 57</b> , to <b>May 8, 19 57</b> , that I last saw the deceased alive on <b>May 8, 19 57</b> , and that death occurred at <b>1:25 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b> DATE SIGNED <b>5/8/57</b>							
ACTUAL SIGNATURE <b>Peter B. H'Doubler</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Peter B. H'Doubler, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 10, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Leakesville</b>		22d. LOCATION (City town or county) (State) <b>Luray Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. B. G. Boudler</b> ADDRESS <b>Luray, Va.</b>				24a. REC'D BY REGISTRAR DATE <b>5-11-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. This page must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 13 1957

RECEIVED

05298

## CERTIFICATE OF DEATH

05340

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 hrs 20 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bonnie</u> Middle <u>Louise</u> Last <u>Hutchison</u>				4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-9-56</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Morris Hutchison</u>				14. MOTHER'S MAIDEN NAME <u>Anne Muderman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Tuberculous Bronchopneumonia</u>							<u>4 hrs</u>
441X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO							
(c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11:30 p. 5-16, 1957</u> , to <u>3:30 p. 5-17, 1957</u> , that I last saw the deceased alive on <u>5-17-57</u> , and that death occurred at <u>3:30 p. M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, State)				DATE SIGNED			
ACTUAL SIGNATURE <u>Ruth Standard M.D.</u>				<u>Washington San Hosp</u> <u>5-17-57</u>			
PHYSICIAN'S NAME (Type) <u>Ruth Standard</u>				<u>Takoma Park</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 20, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Pasche Sons Hyattsville Md.</u>				ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR <u>J. Miller</u> 24b. REGISTRAR'S SIGNATURE <u>W. D. D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

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BUREAU V. B.

MAY 21 1957

RECEIVED



05368

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>D. C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>				c. LENGTH OF STAY IN 1b <b>119 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle <b>Andre</b> Last <b>Inman</b>				4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 29, 1926</b>	9. AGE (In years, in days) <b>31 yrs</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>N. John Ferguson</b>				14. MOTHER'S MAIDEN NAME <b>Regina Campbell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>301-22-7359</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Cervix</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchopneumonia (L) lung</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>491X</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month <b>19</b>	Day <b>19</b>	Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <b>January 31, 1957</b> , to <b>May 30, 1957</b> , that I last saw the deceased alive on <b>May 30, 1957</b> , and that death occurred at <b>11:33 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert Austin Milch</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>6-1-57</b>			
PHYSICIAN'S NAME (Type) <b>ROBERT AUSTIN MILCH, M. D.</b>				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-5-57</b>		22c. NAME OF CEMETERY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b> ADDRESS <b>Wash. D.C.</b>				24. RECEIVED BY REGISTRAR <b>JUN 5 1957</b> DATE		25. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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45

BUREAU V. S.

JUN 5 1967

RECEIVED

05369

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Maple Lane Nursing Home</b>		e. STREET ADDRESS <b>7120 Maple Avenue</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LUCRETIA JACKSON</b>		4. DATE OF DEATH Month Day Year <b>MAY 2 1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/28/1870</b>
9. AGE (In years last birthday) <b>87</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. War Dept. Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Israel Mauditt Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. Parris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Dr. Ruth Jackson</b>		Address <b>5404 Illinois Ave., N.W. Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>4x0.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) <b>ESSENTIAL HYPERTENSION</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MARCH 1, 1952</b> to <b>MAY 2, 1957</b> , that I last saw the deceased alive on <b>MAY 2, 1957</b> , and that death occurred at <b>3:15 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Henry M. Lowden</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>5206 NORWAY DR. 5/1/57</b>	
PHYSICIAN'S NAME (Type) <b>HENRY M. LOWDEN</b>		<b>CHEVY CHASE, MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/4/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Kines Co.</b>		ADDRESS <b>2901 14th St., N.W. Washington, D.C.</b>	
24a. REC'D BY REGISTRAR <b>MAY 3 1957</b>		24b. REGISTRAR'S SIGNATURE <b>James P. [Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. A.

MAY 3 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05370

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05343

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>812 "G" St., S.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Earl</u> Last <u>JACOBS</u>				4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4 Jan. 1900</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>US MARINE CORPS</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>US GOV'T</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William R. Jacobs</u>				14. MOTHER'S MAIDEN NAME <u>Blanch Sale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>WW-II</u>		17. INFORMANT <u>Official Navy Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> DUE TO (a), stating the underlying cause last. (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart, MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	
				22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chamber's Funeral Home</u>				24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	
Chamber's Funeral Home, 517 11th St., S.E. Wash. DC				DATE <u>5-30-57</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

1 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05344  
05371 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>MONTGOMERY</b>	MARYLAND	STATE <b>MARYLAND</b>	COUNTY <b>MONTGOMERY</b>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>SILVER SPRING</b>	LENGTH OF STAY (in this place) <b>8 yrs</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>SILVER SPRING</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>2106 ROSS ROAD</b>		STREET ADDRESS (If rural give location) <b>2106 ROSS ROAD</b>	
3. NAME OF DECEASED: (Type or Print) <b>Christine LAYNAUD JAQUES</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>MAY 27 1957</b>	
5. SEX: <b>FEMALE</b>	6. COLOR OR RACE: <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH: <b>NOV. 22, 1885</b>
9. AGE last birthday <b>71</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country): <b>Louisiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>AUGUSTE LAYNAUD</b>		14. MOTHER'S MAIDEN NAME: <b>ANNAIS CROZIER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>NO</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>436-03-1508 A</b>	
17. INFORMANT & ADDRESS: <b>Mr. Theodore Jaques, 2106 Ross Rd. Silver Spring, Md.</b>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>CARCINOMATOSIS, primary under</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>	
ANTECEDENT CAUSE (B) <b>examined.</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <b>April 4 1957</b>		19B. MAJOR FINDINGS OF OPERATION: <b>CARCINOMATOSIS</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <b>MAY 26, 1957</b> , to <b>MAY 26, 1957</b> , that I last saw the deceased alive on <b>MAY 26, 1957</b> , and that death occurred at <b>7:35 A.M.</b> , from the causes and on the date stated above.			
SIGNATURE <b>Alfred Bigaglio</b>		ADDRESS <b>2005 EYE NW DC.</b> DATE SIGNED <b>27 May 57</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>5/29/57</b>	
NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>		LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>5-31-57</b>		REGISTRAR'S SIGNATURE <b>Frances C. Miller</b>	
24. FUNERAL DIRECTOR <b>Wm. E. Humphrey</b>		ADDRESS <b>SILVER SPRING, MARYLAND</b>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 6 1957

BUREAU V. S.



05372

Items 11, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

## CERTIFICATE OF DEATH

05345

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>MontG.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		d. STREET ADDRESS <b>2430 Pa Ave NW</b>	
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>Kenneth Flemming Jenks</b>		4. DATE OF DEATH <b>May 13 1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-1-96</b>
9. AGE (In years last birthday) <b>60</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ILL.</b>	
11. BIRTHPLACE (State or foreign country) <b>ILL.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>James B. Jenks</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Newcombe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HOSPITAL RECORD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>154X METASTATIC CARCINOMA OF LUNGS</b> DUE TO (b) <b>CARCINOMA OF RECTUM</b> DUE TO (c) <b>GENERALIZED CARCINOMATOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 MONTHS</b> <b>5 1/2 YRS</b> <b>18 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DECUBITUS? ULCER PRE-SACRAL</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MARCH 30, 1950, to May 13, 1957</b> , that I last saw the deceased alive on <b>May 12, 1957</b> , and that death occurred at <b>3:15 A.M.</b> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <b>Robert G. Angle</b>		M.D. <b>5009 Dec Roy Ave, Bethesda, Md 2/13/57</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>5/15/57</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Fair Lakes</b>		22d. LOCATION (City, town, or county) (State) <b>Washington DC</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chevy Chase Fun. Home.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE 5-17-57</b>		24b. REGISTRAR'S SIGNATURE <b>Beattie McShannon</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05346

05373

## CERTIFICATE OF DEATH

Reg. Dist. No.

210

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montg. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 16 (Bethesda)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>5526 Monsey Lane</u>	
3. NAME OF DECEASED (Type or print) <u>BABY GIRL JOHNSON</u>		4. DATE OF DEATH <u>MAY 19<sup>th</sup> 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 19, 1957</u>
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>1</u> Hours <u>30</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WESLEY JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELIZA DORSEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MOTHER</u>		Address <u>— SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY - (weight 9oz)</u> <u>716X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 30 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that I attended the deceased from <u>MAY 19, 1957</u> to <u>MAY 19, 1957</u> , that I last saw the deceased alive on <u>MAY 19, 1957</u> and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2203 Wyoming Ave., N.W.</u> DATE SIGNED <u>—</u>			
ACTUAL SIGNATURE <u>Int. H. Brown</u>		M.D. <u>2203 Wyoming Ave., N.W.</u>	
PHYSICIAN'S NAME (Type) <u>6 Mosvenor</u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/24/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park,</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Snowden</u>		24a. REC'D BY REGISTRAR <u>MAY 27 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>

RECEIVED  
MAY 27 1957  
BUREAU V. E.

05374

## CERTIFICATE OF DEATH

05347,  
216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley Ind</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAPLE LANE NURSING HOME</u>		d. STREET ADDRESS <u>6103 Arbor St</u>	
3. NAME OF DECEASED (Type or print) First <u>ELBERT</u> Middle <u>H</u> Last <u>JOHNSON</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 5, 1874</u>
9. AGE (In years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired US Govt Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bluemont Va</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard M Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Emily Pidgeon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Richard M Johnson</u>	
17. INFORMANT <u>Richard M Johnson</u>		Address <u>6103 Arbor St Chesley Ind</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDITIS</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC MYOCARDITIS</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>APRIL 23</u> , 19 <u>57</u> , to <u>MAY 31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MAY 31</u> , 19 <u>57</u> , and that death occurred at <u>12:22 PM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D.		ADDRESS (Street, city or town, state) <u>520 G Norway St Chesley Ind</u>	
DATE SIGNED <u>5-31-57</u>			
PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6-3-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leaf Funeral Home</u>		ADDRESS <u>4812 Ga Ave NW</u>	
24a. REC'D BY REGISTRAR <u>WIN 4</u>		24b. REGISTRAR'S SIGNATURE <u>Francis J. [illegible]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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JUN 4 1957

BUREAU V. 3

may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05375

## CERTIFICATE OF DEATH

Reg. Dist. No.

05348

114

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MARLEA NURSING HOME</b> <b>14,511 Colesville Road</b>				e. STREET ADDRESS <b>MARLEA NURSING HOME</b> <b>14,511 Colesville Road</b>			
3. NAME OF DECEASED (Type or print) First <b>FLORENCE B.</b> Middle <b>JOHNSON</b> Last				4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/28/82</b>	9. AGE (In years last birthday) <b>74</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dress maker (retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>FRANCE</b>	
10c. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>RAUL DeLABRUYRE</b>				14. MOTHER'S MAIDEN NAME <b>JULIA LARD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Mrs. Bertha Myers, Marlea Nursing Home Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma (primary site unknown)</b> 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2) Hypertensive Cardiovascular disease</b> <b>Arteriosclerosis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>55</b> to <b>May 22</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 21</b> , 19 <b>57</b> , and that death occurred at <b>4:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John S. Rogers</b>		M.D.		ADDRESS (Street, city or town, state) <b>1919 Luminary Rd. Silver Spring, Md.</b>		DATE SIGNED <b>5-22-57</b>	
PHYSICIAN'S NAME (Type) <b>JOHN S. ROGERS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/23/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>SILVER SPRING, MONTGOMERY CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter B. Humphrey</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>5/31/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Frances J. Miller</b>			

RECEIVED

JUN 6 1957

BUREAU V. S.



05376

## CERTIFICATE OF DEATH

05350

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Virginia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>1401 N. Taylor Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Henry</u> Last <u>JONES</u>		4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 Feb. 1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Moulder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Manufacturing</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Jones</u>		14. MOTHER'S MAIDEN NAME <u>Emma Goodwin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>(Daughter) Mildred E. Jones (Same As #1)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate with</u> <u>177x</u> DUE TO <u>metastases.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Indef.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2 February, 1957</u> , to <u>8 May, 1957</u> , that I last saw the deceased alive on <u>8 May, 1957</u> , and that death occurred at <u>9:10 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Melvin Rotner</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md. 5-9-57</u>	
PHYSICIAN'S NAME (Type) <u>Melvin Rotner, Lt., MC, USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-11-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wicks Funeral Home</u>		ADDRESS <u>3034 14th St., N.W. Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>DATE 5-9-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary C. Russell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

MAY 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05351

05377

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>16 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Littleton</b> Last <b>Justice</b>		4. DATE OF DEATH <b>May 14 1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 8, 1888</b>
9. AGE (In years last birthday) <b>68 yrs</b>		IF UNDER 1 YEAR: Months <b>14</b> Days <b>19</b> Hours <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ship Carpentry</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Justice</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Parks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Edward Justice-</b> Address <b>Hyattsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pyloric obstruction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma, stomach</b> DUE TO (c) <b>Peptic ulcer (p?)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 wks.</b> <b>1 yr.</b> <b>ok? yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cirrhosis of liver</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Apr. 27, 1957</b> to <b>May 14, 1957</b> , that I last saw the deceased alive on <b>May 14, 1957</b> , and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>5/14/57</b>			
ACTUAL SIGNATURE <b>Philip H. Varner</b> M.D.		PHYSICIAN'S NAME (Type) <b>Philip H. Varner</b> <b>Bethesda, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/17/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Crisfield Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons,</b>		ADDRESS <b>Crisfield, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>5/21/57</b>		24b. REGISTRAR'S SIGNATURE <b>Beaufort Thompson</b>	

BUREAU V. B.

1957

RECEIVED

05378

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY in 1b <u>28 days</u>				d. STREET ADDRESS <u>4905-Asbury Dr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ESTILL</u> First <u>KEARNEY</u> Middle Last				4. DATE OF DEATH <u>MAY 22 1957</u> Month Day Year			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug-3-79</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Monahan</u>		14. MOTHER'S MAIDEN NAME <u>Mary Curran</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Richard D. Kearney - son.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) Malnutrition</u>							
DUE TO <u>(2) Mental &amp; physical exhaustion</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>(b) Heart attack &amp; infection</u>							
DUE TO <u>(c) pneumonia</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>March 26, 1957</u> to <u>May 21, 1957</u> , that I last saw the deceased alive on <u>March 19, 1957</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. William L. Joyce</u>				DATE SIGNED <u>May 22 1957</u>			
PHYSICIAN'S NAME (Type) <u>Dr. William L. Joyce</u>				ADDRESS (Street, city or town, state) <u>5106 Maple St. S.W. Wash. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>May 22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert X. Murphy</u>				ADDRESS <u>Ed. Va</u>		24a. REC'D BY REGISTRAR <u>DATE 5-29-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Beau M. Thompson</u>							

RECEIVED  
JUN 3 1957  
BUREAU V. S.

05379

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>206 King William Dr.</u>				d. STREET ADDRESS <u>206 King William Dr.</u>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Marie</u> Last <u>KEEGIN</u>				4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14, 1913</u>	9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing - Housewife</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing - Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Arvid Elihn</u>				14. MOTHER'S MAIDEN NAME <u>Sigrid Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW II</u>		17. INFORMANT <u>Leonard B. Keegin</u> Address <u>Olney Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Left adrenal adenoma</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>440A</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>11</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 1956, to <u>May</u> , 1957, that I last saw the deceased alive on <u>May 5</u> , 1957, and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard A. Yates</u> M.D.				ADDRESS (Street, city or town, state) <u>Olney, Md.</u> DATE SIGNED <u>5-5-57</u>			
PHYSICIAN'S NAME (Type) <u>Richard A. YATES</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 7, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LATE OF HEAVEN</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond Barber, Laytonville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>5-6-57</u>		24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Fowler</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requirement that the death certificate be executed within 72 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be completed for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

111

RECEIVED

BUREAU V. B.

MAY 9 1957

RECEIVED



Reg. Dist. No. 05354

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>57 days</b>	
d. NAME OF HOSPITAL (If not in institution, write name of institution) <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Joseph</b> Last <b>Kemp</b>		4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 February 1895</b>
9. AGE (In years last birthday) <b>62</b> yrs		IF UNDER 1 YEAR Months <b>62</b> Days <b>2</b> Hours <b>57</b> Min.	IF UNDER 24 HRS Months <b>62</b> Days <b>2</b> Hours <b>57</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Professional</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Simon J. Kemp</b>		14. MOTHER'S MAIDEN NAME <b>Kate Worthington</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Adrenal Metastases</b> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Renal Cell Carcinoma</b> DUE TO (c) <b>Arteriosclerosis generalizod</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 6, 1957</b> , to <b>May 2, 1957</b> , that I last saw the deceased alive on <b>May 2, 1957</b> , and that death occurred at <b>5:20 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John Laszlo, M.D.</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center National Institutes of Health Bethesda 14, Md.</b>	
PHYSICIAN'S NAME (Type) <b>John Laszlo, M. D.</b>		DATE SIGNED <b>5/3/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/6/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 5-6-57</b>	
24b. REGISTRAR'S SIGNATURE <b>James H. ...</b>			

**ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of the death. The physician may be retained by the hospital or attending physician.

BUREAU V. A.

MAY 7 1957

RECEIVED

05381

## CERTIFICATE OF DEATH

05355

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hosp. Inc.</b>				d. STREET ADDRESS <b>RFD #1</b>		15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Maud</b> Middle <b>Elizabeth</b> Last <b>Keneipp</b>				4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/17/90</b>		9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sect'y. (retired) L.C. Smith Typewriter Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>pennsylvania</b>		11. BIRTHPLACE (State or foreign country) <b>United States</b>	
13. FATHER'S NAME <b>John M. Leonard</b>				14. MOTHER'S MAIDEN NAME <b>Lydia B. Lauver</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>578-01-2610</b>		17. INFORMANT <b>Hospital Record</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis coronary artery disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive heart failure</b> DUE TO (c) <b>Uterine fibroids</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b> <b>3 months</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>X</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 1956, to <b>May</b> , 1957, that I last saw the deceased alive on <b>May 7</b> , 1957, and that death occurred at <b>9:00 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>5/7/57</b>			
PHYSICIAN'S NAME (Type) <b>A.D. Bonifant, M.D.</b>				Sandy Spring, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/10/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGE COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter C. Humphrey</b>				ADDRESS <b>SILVER SPRING, MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>5-9-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 81

2 1957

RECEIVED

05382

## CERTIFICATE OF DEATH

05356, 4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colesville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mary Lee Nursing Home</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Frances</b> Last <b>Kidd</b>				4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1874</b>	
9. AGE (In years last birthday) <b>83</b>		IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>19</b> Min <b>57</b>		IF UNDER 24 HRS Hours <b>19</b> Min <b>57</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Mould (?)</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Redeker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Capt. F. F. Agens, USN, 1433 Harbor Oaks Rd., Jacksonville 7, Florida</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4:20.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis and hypertensive heart disease</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>28 hrs</b> <b>Yes</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>01</b> Month <b>19</b> Day <b>19</b> Year <b>1957</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 30, 1949</b> to <b>May 10, 1957</b> , that I last saw the deceased alive on <b>May 9, 1957</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John S. Rogers</b> M.D.				ADDRESS (Street, city or town, state) <b>1919 Seminary Rd., Silver Spring, Md.</b> DATE SIGNED <b>May 10, 1957</b>			
PHYSICIAN'S NAME (Type) <b>John S. Rogers</b>				1919 Seminary Rd., Silver Sp., Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>5/10/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Bawls Sonas</b>				ADDRESS <b>1756 Pa. Ave. N.W. D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE 5/15/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Francis Potter</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 20 1957

RECEIVED

05383

## CERTIFICATE OF DEATH

05357

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 478</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>3005 Lind St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>Grace</u> Last <u>WINNER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 March 1903</u>
9. AGE (In years last birthday) <u>54</u> yrs		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>Alexander P. Grice</u>		14. MOTHER'S MAIDEN NAME <u>Susan T. Brooks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>(Husband) Edwin G. Kintner (Same As #2)</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoid, intestinal with widespread metastases</u> DUE TO (b) <u></u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>29 Jan.</u> , 1957, to <u>6 May</u> , 1957, that I last saw the deceased alive on <u>6 May</u> , 1957, and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u></u>			
ACTUAL SIGNATURE <u>G. W. Russell</u> M.D.		U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) <u>G. W. Russell, Capt, MC, USN</u>		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATON, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>5-9-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Waller's &amp; Sons, 1756 Penn. Ave., N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE 5-6-57</u>	24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 10 1957

RECEIVED



05299

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH o COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
c. LENGTH OF STAY IN 1b <u>54 Hrs.</u>				d. STREET ADDRESS <u>700 Chillum Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>(NMN)</u> Last <u>Knopp</u>				4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>II-10-84</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Solomon Ferdman</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Malinsky</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u> years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>May 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 17</u> , 19 <u>57</u> , and that death occurred at <u>3 4</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>  </u>				DATE SIGNED <u>  </u>			
ACTUAL SIGNATURE <u>Isidore Shulman</u> M.D. <u>95-19 St. N.W.</u>							
PHYSICIAN'S NAME (Type) <u>I. Shulman</u>				<u>Wash. 6. D. C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>May 19, 1954</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Willard Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pineblow, L. 2 New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>				ADDRESS <u>254 Carroll St. N.W. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>5/20/57</u>	
24b. REGISTRAR'S SIGNATURE <u>  </u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 21 1957

RECEIVED

05384

CERTIFICATE OF DEATH

05359

Reg. Dist. No. 516

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5852 Marbury Road</b>				d. STREET ADDRESS <b>5852 Marbury Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>A.</b> Last <b>KOEHLER</b>				4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/22/91</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>23</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Glazing</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>							
13. FATHER'S NAME <b>George A. Koehler</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Fluke</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mrs Katherine M, Koehler-Item#2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia hypostatic, terminal</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac failure</b> DUE TO (c) <b>Rheumatic heart disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2da</b> <b>24p3</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Osteoarthritis, spinal</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 13, 1957</b> to <b>May 15, 1957</b> , that I last saw the deceased alive on <b>May 15, 1957</b> , and that death occurred at <b>2:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Bethesda, Md.</b> DATE SIGNED <b>5/15/57</b>							
ACTUAL SIGNATURE <b>Philip H. Varner</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Philip H. Varner, M.D.</b>				10620 Georgia Avenue, Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/18/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		22d. LOCATION (City, town, or county) (State) <b>Aspen Hill, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bethesda, Md. Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>5-20-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05385

CERTIFICATE OF DEATH

05360

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>20 min's</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
		f. STREET ADDRESS <b>10100 Cedar Lane</b>	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Philip J Kolb</b>		4. DATE OF DEATH <b>May 18 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 6, 1886</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <b>Postal Supervisor Retired U.S. Govt.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>New York State</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Albert Kolb</b>		14. MOTHER'S MAIDEN NAME <b>Mary Coughlin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Ruth Wenrick</b>		Address <b>10100 Cedar Lane, Kensington, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>120.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary occlusion</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hours</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arterio sclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 12, 1956</b> to <b>May 18, 1957</b> , that I last saw the deceased alive on <b>May 18, 1957</b> , and that death occurred at <b>7:50 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Adelphi S. Porton</b>		M.D. <b>4711 Highland Ave</b>	
PHYSICIAN'S NAME (Type) <b>Bethesda 14, Md.</b>		DATE SIGNED <b>5/18/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>5/19/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>North Wood</b>		22d. LOCATION (City, town, or county) (State) <b>Philadelphia, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		ADDRESS <b>—</b>	
24a. REC'D BY REGISTRAR <b>DATE 5-21-57</b>		24b. REGISTRAR'S SIGNATURE <b>B. M. Pumphrey</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 21

1957

RECEIVED

05386

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 41</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>1504 VAN BUREN ST NW</u>			
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>David</u> Last <u>Lamie</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>16</u> Year <u>1951</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-15-82</u>	9. AGE (In years last birthday) <u>41</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>chemical engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Lamie</u>				14. MOTHER'S MAIDEN NAME <u>Liza Clarke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Wesph record</u>		17. INFORMANT <u>Wesph record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-15-55</u> , 19 <u>55</u> , to <u>5-16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-9-57</u> , 19 <u>57</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Andrew J. Betz</u> M.D.				ADDRESS (Street, city or town, state) <u>5412 Colo. Ave. N.W.</u>		DATE SIGNED <u>5-10-57</u>	
PHYSICIAN'S NAME (Type) <u>Andrew J. Betz</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company</u>				ADDRESS <u>Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>5/10/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>David Thompson</u>			

BUREAU V. M.

M 13 1957

RECEIVED



05387

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>				c. LENGTH OF STAY IN 1b <b>12 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>Patricia Dee Land</b>				4. DATE OF DEATH Month Day Year <b>May 31 1957</b>			
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 25, 1951</b>		9. AGE (In years last birthday) yrs <b>5</b>	F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>James T. Land</b>				14 MOTHER'S MAIDEN NAME <b>Grace Crawford</b>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17 INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>LONG. Heart Disease - Ventricular</b> DUE TO <b>rupture of aorta - fatal septal defect</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Death at time of surgery</b> (c) <b>Death at time of surgery</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 19</b> , 19 <b>57</b> , to <b>May 31</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 31</b> , 19 <b>57</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>6/1/57</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE <b>Richard J. Sanders, M.D.</b>				PHYSICIAN'S NAME (Type) <b>Richard J. Sanders, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/4/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				24a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 5 1957

BUREAU V. S.

05388

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		d. STREET ADDRESS <u>137 OXFORD ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>ALBERT</u> Last <u>LANE</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 2 - 1868</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ARCHITECT</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES P. LANE</u>		14. MOTHER'S MAIDEN NAME <u>EMMA PILLSBURY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>DONALD E. LANE</u>		Address <u>37 OXFORD ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary emboli</u>			
433.1 DUE TO (b) <u>Thrombosis of Rt. auricular appendage</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Auricular Fibrillation</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic nephrosclerosis &amp; terminal uremia</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , to <u>May 28, 1957</u> , that I last saw the deceased alive on <u>May 27, 1957</u> , and that death occurred at <u>6:30 a.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u> M.D.		ADDRESS (Street, city or town, state) <u>3921 Ingomar St. N.W.</u> DATE SIGNED <u>5-28-57</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		<u>Wash 15 D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Cremation</u>		<u>May 28 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Cedar Hill Crematory</u>		<u>Seatons Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Cheryl Chase Funeral Home</u>		<u>5703 W. 1st St.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>DATE 5-29-57</u>		<u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 3 1961

RECEIVED  
JUN 3 1961  
U.S. DEPT. OF JUSTICE

05389

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 27 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>4321 Rosedale Ave.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Annette</b> Middle <b>Blanche</b> Last <b>LEMON</b>		4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 July 1875</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Henry Small</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Small</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>(Son-in-law) William J. Carroll (Same As #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>007X</b> DUE TO <b>Septicemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b) Septicemia</b> <b>(c) Probable following Col. H.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 days</b> <b>6 weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Septicemia</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>9 p.m. 3-25-57</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Bethesda,</b> (County) <b>M.D.</b> (State) <b>MARYLAND</b>	
21. I certify that I attended the deceased from <b>26 March</b> , 19 <b>57</b> , to <b>12 May</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12 May</b> , 19 <b>57</b> , and that death occurred at <b>2:05 P.M.</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md. 5-1-57</b> DATE SIGNED			
ACTUAL SIGNATURE <b>J. W. B. Carroll, Jr.</b> M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>J. W. B. Carroll, Jr., M.D., U.S.N.</b> <b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12 May 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Jedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Washington, D. C.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Lee Son Co.</b> ADDRESS <b>300-44th St.</b>		24. REC'D BY REGISTRAR <b>DATE 5-13-57</b>	
25. REGISTRAR'S SIGNATURE <b>Mary L. Carroll</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 14 1957

RECEIVED

05390

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
c. LENGTH OF STAY IN 1b <b>3d. yrs</b>				d. STREET ADDRESS <b>4885 Battery Lane</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Hodge</b> Middle <b>None</b> Last <b>Lester</b>		4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>19 57</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>December, 6, 1892</b>		9. AGE (In years last birthday) <b>64</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>25</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Attorney</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James Lester</b>				14. MOTHER'S MAIDEN NAME <b>Dona Hillman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>253-01-4333</b>		17. INFORMANT <b>Irene F Lester</b> Address <b>4885 Battery Lane, Bethesda, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO <b>3 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cerebral thrombosis</b> DUE TO (c) <b>generalized arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4.0.0.1</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 27</b> , 19 <b>57</b> , to <b>May 1</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>April 30</b> , 19 <b>57</b> , and that death occurred at <b>5:15</b> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wilfred R. Ehrmantrant</b> M.D.				ADDRESS (Street, city or town, state) <b>4861 A Battery Lane, Bethesda</b>			
PHYSICIAN'S NAME (Type) <b>Wilfred R. Ehrmantrant</b>				DATE SIGNED <b>5/1/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/6/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>5-2-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 3 1957

BUREAU V. S.



05391

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ednor</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montg. Co. Gen Hosp</b>				d. STREET ADDRESS <b>Cedar Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Fra nk</b> Middle <b>M</b> Last <b>Ludwick</b>				4. DATE OF DEATH Month <b>5</b> Day <b>8</b> Year <b>57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4/5/90</b>		9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Butler, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Ludwick</b>				14. MOTHER'S MAIDEN NAME <b>McConnell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WW #1</b>		17. INFORMANT Address <b>Mr. Ken P. Allen, Cedar Lane, Ednor, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>5/9/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>5/11/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGE COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>				ADDRESS <b>Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR <b>5-10-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Estelle B. Lanier</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 8

1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05367  
 Reg. Dist. No. 215

05313

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <span style="float:right">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float:right">b. COUNTY <b>Montgomery</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>12818 Evanston Street</b>					/ d. STREET ADDRESS <b>12816 Evanston Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-around;"><span>First <b>Janet</b></span><span>Middle <b>Gail</b></span><span>Last <b>MAIELLO</b></span></div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-around;"><span>Month <b>May</b></span><span>Day <b>29</b></span><span>Year <b>19 57</b></span></div>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 22, 1955</b>		9. AGE (In years last birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Richard F. MAIELLO</b>				14. MOTHER'S MAIDEN NAME <b>Amy FRASER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Richard F. MAIELLO</b>		Address <b>(Same as #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b><del>None</del> Drowning</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Child drowned in bathtub at home</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Rockville</b>		(County) <b>Montgomery</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) <b>Frank J. BROSCHART, M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>May 29, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-3-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Pumphrey</i> <b>R. A. Pumphrey, 7557 Wisconsin Ave., Bethesda,</b>				ADDRESS <b>Maryland</b>		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE <i>James L. ...</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUN 8 1967

BUREAU V. S.

05392

## CERTIFICATE OF DEATH

Reg. Dist. No.

10385  
05368

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) District of Columbia b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN 1b 36 days	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e STREET ADDRESS 4201 Massachusetts Avenue, N.W.	
3 NAME OF DECEASED (Type or print) First Elizabeth Middle Cady Last Malchenson		4. DATE OF DEATH Month May Day 29 Year 19 57	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH October 10, 1907
9 AGE (n years last birthday) 49 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Office Supplies	
11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME Francis Winn		14. MOTHER'S MAIDEN NAME Clara Spear	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO Unascertainable	
17 INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma breast-Widespread Metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 541.1 Duodenal ulcer-perforating; Dermatomyositis			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I attended the deceased from April 23, 1957, to May 29, 1957, that I last saw the deceased alive on May 29, 1957, and that death occurred at 11:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John Laszlo M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
DATE SIGNED 5/30/57			
22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b DATE THEREOF June 1, 1957	
22c NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d LOCATION (City, town, or county) (State) Hagerstown Md.	
23 FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc., Hagerstown, Md.		24a REC'D BY REGISTRAR JUN 10 1957	
24b REGISTRAR'S SIGNATURE J. A. Hart J. Pres			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 10 1957

RECEIVED

05393

## CERTIFICATE OF DEATH

05369

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Bethesda</b>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Jefferson</b>	
c. LENGTH OF STAY IN 1b <b>8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dillonvale</b>	
d. NAME OF HOSPITAL (If not in hospital give name of institution) <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>		d. STREET ADDRESS <b>(None)</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>Thelma</b> Middle <b>May</b> Last <b>Malin</b>		4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>19 57</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>31 March 1919</b>
9. AGE (In years last birthday) <b>38 yrs</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>1</b> Days <b>10</b> Hours <b></b> Min <b></b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>None</b>	11 BIRTHPLACE (State or foreign country) <b>Ohio</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Henry Roberts</b>		14 MOTHER'S MAIDEN NAME <b>Maudie Propst</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17 INFORMANT <b>The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]			
PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Hemorrhage</b> <b>204.1</b> DUE TO <b>Rupture of Spleen</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Acute Myelocytic Leukemia</b> (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) <b>Dillonvale</b>		(County) <b>Ohio</b> (State) <b>Ohio</b>	
21. I certify that I attended the deceased from <b>May 3, 1957</b> , to <b>May 11, 1957</b> , that I last saw the deceased alive on <b>May 11, 1957</b> , and that death occurred at <b>3:55 A.M.</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>		DATE SIGNED <b>5/11/57</b>	
ACTUAL SIGNATURE <b>Arthur J. Garceau</b> M.D.			
PHYSICIAN'S NAME (Type) <b>ARTHUR J. GARCEAU, M. D.</b>			
22a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b DATE THEREOF <b>5/11/1957</b>	22c NAME OF CEMETERY OR CREMATORY <b>Dillonvale</b>	22d LOCATION (City, town or county) <b>Dillonvale</b> (State) <b>Ohio</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md</b>		24a REC'D BY REGISTRAR <b>DATE 5-14-57</b> 24b REGISTRAR'S SIGNATURE <b>Bessie M. Shoup</b>	

TO INITIAL ATTENDING PHYSICIAN. The law requires that the death certificate be completed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal.

BUREAU V. R.

MAY 16 1957

RECEIVED



05370

MARYLAND

STATE DEPARTMENT OF HEALTH

05394

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Kensington</u> TOWN <u>Kensington</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Maryland</u> TOWN <u>Kensington</u> STREET ADDRESS (If rural, give location) <u>10528 Wheatley Street</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Lucie</u> (Middle) <u>M</u> (Last) <u>Marshall</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>28</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>10/20/1873</u>
9. AGE last birthday <u>83</u> yrs. <u>7</u> Months <u>8</u> Days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>New York City</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Voyer</u>		14. MOTHER'S MAIDEN NAME <u>Urainie Marchand</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Norman Smith, 10630 Wheatley St. Ken.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>120.0</u> Immediate cause (a) ... <u>Chronic Congestive Heart Failure</u> Antecedent cause(s) (b) ... <u>Arteriosclerotic Heart Disease</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) ... <u>Cerebral Thrombosis</u>			<u>3 yrs.</u> <u>6 da.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1954</u> to <u>May 28, 1957</u> , that I last saw the deceased alive on <u>May 21, 1957</u> , and that death occurred at <u>5:50 a.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Robert J. Thibodeau, M.D.</u> (Degree or title)		ADDRESS <u>Kensington, Md.</u> DATE SIGNED <u>May 28, 57</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>		DATE <u>5/31/57</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>5-29-57</u>		24. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

JUN 4 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE, 18

05371

05395

## CERTIFICATE OF DEATH

Reg. Dist. No.

211

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cedar Grove</b>		c. LENGTH OF STAY IN 1b <b>10 Years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cedar Grove</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First <b>GEORGIANA</b> Middle <b>MATHIAS</b> Last		4. DATE OF DEATH Month <b>MAY</b> Day <b>5</b> Year <b>19 57</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 18 1876</b>	
9. AGE (In years last birthday) <b>80</b> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>L. D. Shipe</b>		14. MOTHER'S MAIDEN NAME <b>Mathilda Cullers</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, list dates of service) <b>#####</b>		16. SOCIAL SECURITY NO. <b>####</b>		
17. INFORMANT <b>Calvin Miller, Germantown, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>XXXXXXXXXX</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis, severe Diabetes mellitus Osteoarthritis</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>9/27</b> , <b>1955</b> , to <b>5/5</b> , <b>1957</b> , that I last saw the deceased alive on <b>5/5</b> , <b>1957</b> , and that death occurred on <b>11-10</b> P.M. from the causes and on the date stated above.				
ACTUAL SIGNATURE <b>Gilcin F. Meadors</b>		ADDRESS (Street, city or town, state) <b>Damascus, Maryland</b>		
PHYSICIAN'S NAME (Type) <b>Gilcin F. Meadors, M.D.</b>		DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 8 1957</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Flower Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Redland Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ray W. Barber</b>		24a. REC'D BY REGISTRAR <b>May 18/57</b>		
ADDRESS <b>Laytonsville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Della W. Burdette</b>		

BUREAU V. 4

13 1957

RECEIVED

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05396

CERTIFICATE OF DEATH

Reg. Dist. No.

05372  
274

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1000 Helena Drive</u>				d. STREET ADDRESS <u>1000 Helena Drive 1</u>			
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Matthews</u> Last <u>Matthews</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 21, 1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>ROMANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARTIN SCHWARTZ</u>				14. MOTHER'S MAIDEN NAME <u>EDITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>SL. SPR. Md.</u> <u>MRS. ROBERT WHITMAN 2553 FENTON ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>4.2.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Renal failure</u> (c) <u>Arteriosclerotic cardiovascular disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>6 mo.</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 30, 1955</u> to <u>MAY 13, 1957</u> , that I last saw the deceased alive on <u>MAY 13, 1957</u> , and that death occurred at <u>3:20 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond Bradshaw</u>				ADDRESS (Street, city or town, state) <u>345 University Blvd, West Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>				DATE SIGNED <u>MAY 13, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 15, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Sharon Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Nangandiy + Son - 3501 14th St. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>5/15/57</u>		24b. REGISTRAR'S SIGNATURE <u>Shane Potter</u>	

BUREAU V. S.

1957

RECEIVED

05397

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Annapolis)</u>				c. LENGTH OF STAY IN 1b <u>4 Days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>				d. STREET ADDRESS <u>20 3rd St., N.E.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Raymond</u> Last <u>MC CARTHY</u>				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>14 Nov. 1919</u>	
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Senator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Timothy Mc Carthy</u>				14. MOTHER'S MAIDEN NAME <u>Bridget Tierney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 8-12-42 to 2-20-45</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Official Nat. Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatitis, acute, cause unknown</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>							
21. I certify that I attended the deceased from <u>23 April</u> , 19 <u>57</u> , to <u>2 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2 May</u> , 19 <u>57</u> , and that death occurred at <u>8:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>5-3-57</u>							
ACTUAL SIGNATURE <u>C. U. Shilling</u>				M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>C. U. Shilling, M.D.</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Appleton, Wisconsin</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Charles Jones</u>				ADDRESS <u>1756 R. Ave N.W. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>5-3-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary L. Russell</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 6 1957

BUREAU V. S.



05398

CERTIFICATE OF DEATH

05374 216

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE <b>District of Columbia</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>		c LENGTH OF STAY IN 1b <b>7 days</b>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Washington</b>	
3 NAME OF DECEASED (Type or print) First <b>Lottie</b> Middle <b>Frances</b> Last <b>McDuffie</b>		4 DATE OF DEATH Month <b>May</b> Day <b>15</b> , Year <b>19 57</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>September 19, 1892</b>
9 AGE (In years last birthday) <b>64</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleswoman</b>	
10b KIND OF BUSINESS OR INDUSTRY <b>Salesmanship</b>		11 BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13 FATHER'S NAME <b>Charles Martin</b>	
14 MOTHER'S MAIDEN NAME <b>Julia Clingingpeel</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO <b>577-34-2286</b>		17 INFORMATION <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18 CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL ANOXIA</b> <b>203X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>HYPERTENSION, HYPOTATPEMIA</b> DUE TO (c) <b>MULTIPLE MYELOMA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 Hrs</b> <b>11 Hrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 8,</b> 19 <b>57</b> , to <b>May 15,</b> 19 <b>57</b> , that I last saw the deceased alive on <b>May 15,</b> 19 <b>57</b> , and that death occurred at <b>9:00 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gurston Goldin, M. D.</b>		DATE SIGNED <b>5/15/57</b>	
PHYSICIAN'S NAME (Type) <b>Gurston Goldin, M. D.</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	22b DATE THEREOF <b>5-18-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland Md.</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros.</b>		24a. REC'D BY REGISTRAR <b>1661- Wood Hope Rd SE</b> <b>WASH D.C.</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie Thompson</b>		DATE <b>5/17/57</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

MONTGOMERY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05375
05399										CERTIFICATE OF DEATH
										Reg. Dist. No. 217
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Wray</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>					c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sharon Chronic Hospital</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Flora</u> Middle <u>C.</u> Last <u>McKeand</u>					4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1957</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 4 1864</u>		9. AGE (In years last birthday) <u>92</u> yrs. Months <u>5</u> Days <u>8</u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Nurse</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Newburgh Ontario</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Allen Caton</u>					14. MOTHER'S MAIDEN NAME <u>Charlotte Anne Price</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>					16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Hosp Record</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest - Ren. Sensitivity</u> DUE TO <u>1007</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Art. Schwann's, Splanchnic nerves</u> DUE TO <u>1095</u> (c) <u>Fract Femur - Test &amp; Plate</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 days</u>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell out of bed and sustained fract. &amp; open reduction required</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>3</u> p.m. <u>4-10-57</u> 19 <u>57</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>		20f. (City or town) (County) (State) <u>Olney</u> <u>Montg.</u> <u>Md.</u>	
21. I certify that I attended the deceased from <u>6-1-1954</u> to <u>5-12-1957</u> , that I last saw the deceased alive on <u>11 May 1957</u> , and that death occurred at <u>10:25 AM</u> , from the causes and on the date stated above.										
SIGNATURE <u>John B. Ziegler</u> M.D.					ADDRESS (Street, city or town, state) <u>OLNEY MD</u>					
PHYSICIAN'S NAME (Type) <u>J.B. ZIEGLER</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 14 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LAYTONSVILLE MD</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery</u> <u>MD</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROY W BARBER</u> ADDRESS <u>LAYTONSVILLE MD</u>					24a. REC'D BY REGISTRAR <u>5-16-57</u>		24b. REGISTRAR'S SIGNATURE <u>Sertrude B Lawler</u>			

Postmaster

Chicago

Alton Chicago Hospital

Flora

Female White

Married Nurse

Alton

C. W. Henry

Box # 1884

Newbury Chicago

Charlotte Anne 1902

Post Office

BUREAU V. M.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05400 CERTIFICATE OF DEATH

05376

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montg</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>5321 Glenwood Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Porterfield</u> Last <u>McNabb</u>		4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-22-86</u>
9. AGE (In years, last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenn</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Elliott</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Norvell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Hospt. records</u>	
17. INFORMANT <u>Hospt. records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to Coronary Thrombosis</u> DUE TO (c) <u>Coronary Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. ft.</u> Month <u>  </u> Day <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 18, 1957</u> to <u>May 19, 1957</u> , that I last saw the deceased alive on <u>May 18, 1957</u> , and that death occurred at <u>6:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sidney E. Cousins</u> M.D.		ADDRESS (Street, city or town, state) <u>3921 Luganor Ln NW 5/19/57</u>	
PHYSICIAN'S NAME (Type) <u>SIDNEY E. COUSINS</u>		DATE SIGNED <u>5/19/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	22b. DATE THEREOF <u>5/21/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Nashville, Tennessee</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.,</u>		ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>1/22/57</u>		24b. REGISTRAR'S SIGNATURE <u>Beau Thomson</u>	

BUREAU V. M.

APR 28 1957

RECEIVED

05401

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05377

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>2 hr. 45 min.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbridge</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>Joseph</b> Last <b>MC NALLY</b>				4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>30 May 1953</b>	
9. AGE (in years last birthday) <b>3</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b>		IF UNDER 24 HRS. Hours <b>3</b> Min. <b>3</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Richard J. MC NALLY</b>				14. MOTHER'S MAIDEN NAME <b>Florence Taylor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>(Father) Richard J. MC NALLY (Same As #2)</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage and laceration</b> DUE TO <b>830 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Compound, Multiple Fractures of skull</b> DUE TO <b>5 hours</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Child ran in rear of carbacking out of driveway when struck</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Child ran in rear of carbacking out of driveway when struck</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>8:55</b> P. M. <b>May 23 1957</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>				20f. (City or town) (County) (State) <b>Woodbridge Virginia</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. Frank J. Broschart, MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>24 May 1957</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-29-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fitzgerald Funeral Home, 3245 Wilson Blvd.</b>				ADDRESS <b>Arlington, Va.</b>			
24a. REC'D BY REGISTRAR <b>May 24 1957</b>				24b. REGISTRAR'S SIGNATURE <b>May 24 1957</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
MAY 27 1957  
BUREAU Y. S.



1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 05314 Item 8 Film 215 5-14-57 et  
 CERTIFICATE OF DEATH

05378

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CONGRESSIONAL MANOR SANITARIUM</u>		d. STREET ADDRESS <u>625 Sheridan St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Theresa</u> Middle <u>Mendelson</u> Last <u></u>		4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/31/1911</u>
9. AGE (In years last birthday) <u>45</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C. Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jeremiah Weitz</u>		14. MOTHER'S MAIDEN NAME <u>Bella</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Benj. Mendelson</u>		Address <u>Chillum, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>71x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF CERVIX</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>8 mon's</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>71x</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 4</u> , 19 <u>56</u> , to <u>May 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>57</u> , and that death occurred at <u>9:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James C. Weiner</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>100 Longfellow St. N.W.</u>	
NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 5, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bnei Israel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Oxon Hill Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Langman &amp; Son</u>		ADDRESS <u>3501-14 St. NW D.C.</u>	24a. REC'D BY REGISTRAR <u>DATE 5-7-57</u>
		24b. REGISTRAR'S SIGNATURE <u>Bearish Thompson</u>	

RECEIVED

MAY 9 1957

BUREAU V. S.

## 05300 CERTIFICATE OF DEATH

05379

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Talbot Port</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lanister Sanatorium + Hospital</u>				d. STREET ADDRESS <u>1201 Drexel Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Henry Meredith</u>				4. DATE OF DEATH Month Day Year <u>May 18 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29 1887</u>	
9. AGE (In years last birthday) <u>67 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Machine Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>			
11. BIRTHPLACE (State or foreign country) <u>Penna</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John H. Meredith</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Mann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Hospital Records</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>UREMIA</u> DUE TO (c) <u>MARKED GENERALIZED ARTERIOSCLEROSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>18 HRS.</u> <u>24 HRS.</u> <u>7 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>FEB 14</u> , 19 <u>55</u> , to <u>MAY 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MAY 18</u> , 19 <u>57</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hyattsville Md.</u> DATE SIGNED <u>Harold Sterling</u>							
ACTUAL SIGNATURE <u>Harold Sterling</u>				M.D. <u>1352-44127515-4 NONE</u>			
PHYSICIAN'S NAME (Type) <u>HAROLD STERLING</u>				<u>HYATTSVILLE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>		22b. DATE THEREOF <u>5/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Altoona</u>		22d. LOCATION (City, town, or county) (State) <u>Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>			
24a. REC'D BY REGISTRAR <u>5/31/57</u>				24b. REGISTRAR'S SIGNATURE <u>J. Wilbur Ridd</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 21

MAY 21 1957

RECEIVED

05402

## CERTIFICATE OF DEATH

Reg. Dist. No.

218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>germantown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>germantown</u>	
c. LENGTH OF STAY IN 1b <u>53</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Jane</u> Middle <u>Metz</u> Last		4. DATE OF DEATH <u>May - 3 - 1957</u> Month Day Year	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17 - 1893</u>
9. AGE (In years last birthday) <u>63</u> yrs		10. AGE (In years last birthday) <u>4</u> Months <u>16</u> Days <u>16</u> Hours <u>16</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-keeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>germantown, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Edward Perrell</u>		14. MOTHER'S MAIDEN NAME <u>Lillie A. Page</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-16-0257</u>	
17. INFORMANT <u>William F. Metz, Germantown, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of sigmoid</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb - 2 - 1957</u> to <u>May - 3 - 1957</u> , that I last saw the deceased alive on <u>May - 2 - 1957</u> , and that death occurred at <u>3:34</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7 - Brooks Avenue Gaithersburg, Md.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>William C. Miller</u> M.D.		PHYSICIAN'S NAME (Type) <u>William C. Miller</u> <u>Gaithersburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May - 3 - 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Church Cemetery. Germantown. Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner.</u> ADDRESS <u>Gaithersburg. Md.</u>		24a. REC'D BY REGISTRAR <u>May 6 - 57</u> 24b. REGISTRAR'S SIGNATURE <u>Abner L. Coode</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 10 1957

RECEIVED

05403

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>3700 Mass. Ave. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>B</u> Last <u>Mintener</u>		4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29, 1877</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Northern Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John William Bradshaw</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Balfour</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Bradshaw Mintener</u>		Address <u>4755 Berkeley Terrace Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u> <u>2 yrs. +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>444X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>55</u> , to <u>May 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 3</u> , 19 <u>57</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Karl Portzbach</u> M.D.		ADDRESS (Street, city or town, state) <u>Washington Clinic</u> DATE SIGNED <u>7/3/57</u>	
PHYSICIAN'S NAME (Type) <u>Karl Portzbach M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	22b. DATE THEREOF <u>5/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Minneapolis, Minnesota</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Kines Co.</u> ADDRESS <u>2901-14th St. Wash D.C.</u>		24a. REC'D BY REGISTRAR <u>5/7/57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 7 1957

BUREAU V. S.



05404

## CERTIFICATE OF DEATH

Reg. Dist. No. 16

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Prince William</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>12 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>(None)</b> Last <b>Morgan</b>				4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>57</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>17 March 1907</b>	9. AGE (In years last birthday) <b>50 yrs</b>	F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11 BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Madison Byers</b>				14. MOTHER'S MAIDEN NAME <b>Lizzie Gantley</b>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service)				16 SOCIAL SECURITY NO			
17. INFORMANT <b>The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma uterine cervix</b> DUE TO <b>Extension of carcinoma to uterus, causing extension of uterus - metastatic to lungs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute interstitial nephritis</b> DUE TO <b>Bilateral hydronephrosis &amp; hydronephrosis</b> (c) <b>Bilateral hydronephrosis &amp; hydronephrosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>April 21, 1957</b> to <b>May 3, 1957</b> , that I last saw the deceased alive on <b>May 3, 1957</b> and that death occurred at <b>1:53A M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>Peter B. H'Doubler, M.D.</b>				<b>The Clinical Center</b>			
PHYSICIAN'S NAME (Type) <b>Peter B. H'Doubler, M.D.</b>				<b>National Institutes of Health</b>			
				<b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>5/5/57</b>		<b>Stonewood</b>		<b>Haymarket</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Everly Funeral Home Fairfax</b>				24a. REC'D BY REGISTRAR <b>DATE 5-6-57</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 7 1957

BUREAU V. S.

05405

## CERTIFICATE OF DEATH

05383

Reg. Dist. No.

275246

1. PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a STATE <b>D. C.</b> b COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
c. LENGTH OF STAY IN 1b <b>1 day</b>				d STREET ADDRESS <b>1014 Columbia Road, N. W.</b>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>Thomas</b>		First <b>Clifton</b> Middle <b>Moten</b>		4 DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>19 57</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> D VORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>May 14, 1892</b>		9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Interior Decorator</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Charles Moten</b>				14 MOTHER'S MAIDEN NAME <b>Daisy Jackson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16 SOCIAL SECURITY NO <b>None</b>		17 INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Cachexia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dehydrated Metastasis</b> DUE TO (c) <b>Carcinoma of the esophagus</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) <b>Cirrhosis of liver</b>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I attended the deceased from <b>May 9</b> , 19 <b>57</b> , to <b>May 10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 10</b> , 19 <b>57</b> , and that death occurred at <b>4:40 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>5/11/57</b> NATIONAL INSTITUTES OF HEALTH <b>Bethesda 14, Maryland</b>							
ACTUAL SIGNATURE <b>James R. Jude</b>		PHYSICIAN'S NAME (Type) <b>JAMES R. JUDE, M. D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 15, 1957</b>		22c NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>		22d LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Morgan &amp; Woodford</b> <b>Reg. S. P. Morgan</b>				ADDRESS <b>1622 11th St., N.W.</b> <b>Wash. D. C.</b>		24a. REC'D BY REGISTRAR DATE <b>5/13/57</b>	
				24b REGISTRAR'S SIGNATURE <b>Leslie Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

11 14 1957

RECEIVED

05301

## CERTIFICATE OF DEATH

05384

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>3317 Floral Court</u>	
3. NAME OF DECEASED (Type or print) <u>Infant Boy</u> First Middle Last <u>Muller</u>		4. DATE OF DEATH <u>May 19 1957</u> Month Day Year	
5. SEX <u>Boy</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1957</u>
9. AGE (In years last birthday) yrs. <u>11</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles James Muller</u>		14. MOTHER'S MAIDEN NAME <u>Emily Mac Colie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>3317 Floral Court, Silver Spring</u>	
17. INFORMANT <u>Mother</u>		Address <u>3317 Floral Court, Silver Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>XX</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u> (c) <u>Due to</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-19-57</u> to <u>5-19-57</u> , that I last saw the deceased alive on <u>5-19-57</u> , and that death occurred at <u>10:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. Diamond</u>		ADDRESS (Street, city or town, state) <u>8224 - Ga. Ave. Me</u> DATE SIGNED <u>5/27/57</u>	
PHYSICIAN'S NAME (Type) <u>Herbert H. Diamond</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>5-20-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hosp. Takoma Park, Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M. D. Wash. San. &amp; Hosp. T.P. Md.</u>		24. REC'D BY REGISTRAR <u>JUN 9 - 1957</u> 25. REGISTRAR'S SIGNATURE <u>J. W. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

JUN 10 1954

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05496

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>			c. LENGTH OF STAY IN 1b <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>				d. STREET ADDRESS <b>Box 101</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle <b>Regina</b> Last <b>Murtaugh</b>				4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 13, 1883</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>57</b>		IF UNDER 24 HRS Months <b>7</b> Days <b>19</b> Hours <b>57</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic - house work</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>	
13. FATHER'S NAME <b>Luke E. Murtaugh</b>				14. MOTHER'S MAIDEN NAME <b>Bridgett Agnes Bollen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Hospital Record</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Mesentery of Small Intestine - Primary Site Unknown</b> DUE TO <b>Bowel - Primary Site Unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized osteo-arthritis with ankylosis of knees + elbows</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 29, 1957</b> to <b>May 7, 1957</b> , that I last saw the deceased alive on <b>May 7, 1957</b> , and that death occurred at <b>10:40 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Arthur F. Woodward</b>				M.D. <b>Rockville, Md.</b>			
PHYSICIAN'S NAME (Type) <b>A. F. Woodward, M. D.</b>				Rockville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/10/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walker E. Humphrey</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>5-9-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bertine B. Fowler</b>			

REAU V. H.

18 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05407

Reg. Dist. No. 05386

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg rfd</b>			c. LENGTH OF STAY IN 1b <b>2 mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg RFD</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Route 240</b>				d. STREET ADDRESS <b>U.S. Route 240</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Neal Jr.</b> Last				4. DATE OF DEATH Month <b>May</b> Day <b>24</b> , 1957 Year <b>19</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/2/32</b>		9. AGE (In years last birthday) <b>24</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Forestry</b>		11. BIRTHPLACE (State or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph W. Neal</b>				14. MOTHER'S MAIDEN NAME <b>Bessie D. Berry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Diane Mae Neal (Same as Item 2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage &amp; Laceration</b> <b>176X</b> DUE TO <b>Bullet wound thru skull</b> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.) <b>Self inflicted bullet wound</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>5:24</b> p. m. <b>5/24/57</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Auto</b>		20f. (City or town) (County) (State) <b>Gaithersburg Montg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>5-28-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Clifton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Clifton Texas</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner</b>				ADDRESS <b>Gaithersburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>May 27-57</b>	
				24b. REGISTRAR'S SIGNATURE <u>Abraham G. Cook</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAY 29 1957

BUREAU V. B.

05408

## CERTIFICATE OF DEATH

05387

Reg. Dist. No. 16

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 11, Maryland</b>		c. LENGTH OF STAY IN 1b <b>51 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
f. STREET ADDRESS <b>4309 Bradley Lane</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Isabel</b> Middle <b>Kyle</b> Last <b>Neely</b>		4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 15, 1907</b>
9. AGE (In years last birthday) <b>49</b> yrs		10. IF UNDER 1 YEAR: Months <b>49</b> Days <b>19</b> Hours <b>19</b> Min <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Editorial Assistant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medical Journalism</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Neely</b>		14. MOTHER'S MAIDEN NAME <b>Florence Kyle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>578-01-5260</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL METASTASES</b> <b>110X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF BREAST</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 29</b> , 19 <b>57</b> , to <b>May 19</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 19</b> , 19 <b>57</b> , and that death occurred at <b>3:40 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>5/19/57</b> NATIONAL INSTITUTES OF HEALTH BETHESDA 11, MARYLAND			
ACTUAL SIGNATURE <b>Gurston D. Goldin</b> M.D.		PHYSICIAN'S NAME (Type) <b>Gurston D. Goldin, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/23/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Uniondale Cemt.</b>	22d. LOCATION (City, town, or county) (State) <b>Pittsburgh, Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph H. Birschi's Son</b> ADDRESS <b>Wash., 3034 E. St. N.W. D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE 5-21-57</b> 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05409

## CERTIFICATE OF DEATH

05388

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brighton</u>				c. LENGTH OF STAY IN 1b <u>89</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>				d. STREET ADDRESS <u>none</u>			
3. NAME OF DECEASED (Type or print) <u>Ellen</u> First <u>Elizabeth</u> Middle <u>Wright</u> Last				4. DATE OF DEATH <u>May 9</u> (9) Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 29</u> 19 <u>66</u>		9. AGE (In years last birthday) <u>91</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Holland</u>				14. MOTHER'S MAIDEN NAME <u>Clara Bacon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or date of service)				16. SOC. AL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Mable Hill</u> Address <u>Brighton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cc. Stomach</u> <u>151x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1950</u> ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiac-Vascular Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>March, 1948</u> to <u>5-8-</u> 19 <u>57</u> that I last saw the deceased alive on <u>5-8-</u> 19 <u>57</u> , and that death occurred at <u>6:30</u> A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Calvin B. LeCompte</u>				M.D. <u>61 R St. NE</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Calvin B. LeCompte</u>				DATE SIGNED <u>May 9, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Snowden</u>				ADDRESS <u>Rookville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 5/15/57</u>	
						24b. REGISTRAR'S SIGNATURE	

BUREAU V. 31

MAY 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05410

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring RFD # 1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring RFD # 1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <u>Norbeck - Norwood Rd.</u>		d. STREET ADDRESS <u>Norbeck - Norwood Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Victoria</u> Last <u>O'CONNELL</u>		4. DATE OF DEATH Month <u>5</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 23, 1896</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JEFFERY C. O'CONNELL</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Costello</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or in service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Anna L O'CONNELL</u>		Address <u>Silver Spring RFD # 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line (or (a), (b), and (c)).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u> <u>Yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/28</u> 19 <u>57</u> to <u>5/28</u> 19 <u>57</u> , that I last saw the deceased alive on <u>5/28</u> 19 <u>57</u> , and that death occurred at <u>12:05 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. H. L. IGO</u>		ADDRESS (Street, city or town, state) <u>Silver Spring, Md.</u> DATE SIGNED <u>5/28/57</u>	
PHYSICIAN'S NAME (Type) <u>C. H. L. IGO</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 1</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>mt Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Royce Barber, Laytonville, Md.</u>		24. REC'D BY REGISTRAR DATE <u>6-1-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>			

RECEIVED

JUN 4 1957

BUREAU V. E.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

05411

## CERTIFICATE OF DEATH

05390

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Etchison</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Etchison</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Rfd#2 Gaithersburg, Md.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas (None) Owings</b>				4. DATE OF DEATH Month Day Year <b>May 26 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 11, 1881</b>		9. AGE (In years lost birthday) yrs. <b>76</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Levin I.G. Owings</b>			
14. MOTHER'S MAIDEN NAME <b>Maria Dorsey</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>213-38-0139</b>				17. INFORMANT <b>Gaithersburg, Md. Mrs. Elizabeth Owings, Rfd 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchiectases</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>4 years 3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>506X</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. ft. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>19</b>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>3/11</b> , 19 <b>52</b> , to <b>5/26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5/25</b> , 19 <b>57</b> , and that death occurred at <b>11:01</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b>				M.D. <b>Santig</b> DATE SIGNED <b>5/28/57</b>			
INTERVIEWER'S NAME (Type) <b>Dr. J. W. Bird</b>				ADDRESS <b>Olney, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-29-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville Meth.</b>		22d. LOCATION (City, town, or county) (State) <b>Laytonsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Royce Barber</b>				ADDRESS <b>Cemetery Laytonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>6-1-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

RECEIVED

JUN 4 1957

BUREAU V. 3

## CERTIFICATE OF DEATH

Reg. Dist. No.

05412

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution. Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>U.S. Naval Hospital, Bethesda, Md.</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Roy</u> Last <u>PANTANO</u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 August 1950</u>	9. AGE (In years lost birthday) yrs	IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u>	IF UNDER 24 HRS Hours <u>1</u> Min <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Joseph Pantano</u>				14. MOTHER'S MAIDEN NAME <u>Vivian Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>(Father) James J. Pantano, (Same as above)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTICEMIA</u> DUE TO (b) <u>HYDROCEPHALUS</u> DUE TO (c) <u>MENINGO MYELOCELE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1957</u> Hour o. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>10 April</u> , 19 <u>57</u> , to <u>5 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5 May</u> , 19 <u>57</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>5-7-57</u>							
ACTUAL SIGNATURE <u>Daniel Shupkar</u>				M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Daniel Shupkar, LT, MC, USN</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)				
<u>Burial</u>	<u>5-9-57</u>	<u>Little Flower Cemetery</u>	<u>Great Mills, Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonardtown, Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>	
				DATE <u>5-7-57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05413

## CERTIFICATE OF DEATH

05392

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>105 Indian Spring Drive</b>				d. STREET ADDRESS <b>105 Indian Spring Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Park</b> Last <b>Park</b>				4. DATE OF DEATH May 12, 1957 Month Day Year			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/15/82</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Park Transfer Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Scotland</b>	
13. FATHER'S NAME <b>William Park</b>				14. MOTHER'S MAIDEN NAME <b>Jane Annand</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>William A. Park</b> Address <b>110 Dale Drive S.S. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO <b>CORONARY ATHEROSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>5 yrs.</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>Nov. 1956</b> to <b>12 MAY 1957</b> that I last saw the deceased alive on <b>12 MAY 1957</b> , and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L.B. Snow</b>		M.D. <b>9013 FLOWER AVE.</b>		DATE SIGNED <b>5/12/57</b>			
PHYSICIAN'S NAME (Type) <b>SILVER SPRING, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>5/15/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. Washington, D.C.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>5/14/57</b>	24b. REGISTRAR'S SIGNATURE <b>Francis J. Att...</b>		

BUREAU V. M.

... 14 1957

RECEIVED

05414

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Mont.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksburg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3 NAME OF DECEASED (Type or print) First Middle Last <b>Edward Thurber Paxton</b>				4 DATE OF DEATH Month Day Year <b>May 27 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 26, 1892</b>		9. AGE (In years lost (in days)) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gov. Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fed. Housing</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Milton Paxton</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Boyle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Mrs. James Burdette, Clarksburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of face with generalized metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>metastases</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 5, 1956</b> , to <b>May 27, 1957</b> , that I last saw the deceased alive on <b>May 10, 1957</b> , and that death occurred at <b>12:30 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Damascus, Md.</b> DATE SIGNED							
SIGNATURE <b>James P. Kerr</b>				M.D. <b>Damascus, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. J. P. Kerr</b>				<b>Damascus, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Removal</b>		<b>May 27</b>		<b>St. Stephen</b>		<b>Prince George, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond Barber, Laytonville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>May 28/57</b>		24b. REGISTRAR'S SIGNATURE <b>Della H. Burdette</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

UN. C.

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

05415

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05394

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>7 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11705 Idlewood Rd</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Fredrick</u> Last <u>Pergal</u>		4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-4-1915</u> 41 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>De Police</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>John Pergal</u>		14. MOTHER'S MAIDEN NAME <u>FREDA PERGAL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Maxine Pergal (wife)</u> Address <u># 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage &amp; laceration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>bullet wound thru skull</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Self-inflicted bullet wound</u>	
20c. TIME OF INJURY Month, Day, Year <u>5-3-1957</u> Hour <u>8-PM</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Silver Spring Montg Md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/7/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) <u>ARLINGTON, VIRGINIA</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>MARTIN W. HYSO</u>		ADDRESS <u>1300 N. STREET, N.W. - WASH. D.C. 6</u>	
24a. REC'D BY REGISTRAR <u>5-3-57</u>		24b. REGISTRAR'S SIGNATURE <u>James P. Lathrop</u>	

BUREAU V. S.

MAY 6 1957

RECEIVED

05416

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>				c. LENGTH OF STAY IN 1b <b>361 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ola's</b> Middle <b>Edvins</b> Last <b>Plavnieks</b>				4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 18, 1951</b>	
9. AGE (In years last birthday) <b>5 yrs</b>		F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Wash., D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>V. Richards Plavnieks</b>		14. MOTHER'S M.A.DEN NAME <b>Irene Abols</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Peritonitis and Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dermatomyositis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 1/2 yr.</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4/10 X</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1, 19 56</b> , to <b>May 28, 19 57</b> , that I last saw the deceased alive on <b>May 28, 19 57</b> , and that death occurred at <b>5:30 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center, Bethesda 14, Maryland</b> DATE SIGNED <b>5/29/57</b>							
ACTUAL SIGNATURE <b>K. Lemone Yelding</b> M.D.				PHYSICIAN'S NAME (Type) <b>K. Lemone Yelding</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/1/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Humphrey</b>				ADDRESS <b>Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 5-31-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 4 1937

BUREAU V. E.

## 05417 CERTIFICATE OF DEATH

Reg. Dist. No.

7 X3

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San Hosp</u>		d. STREET ADDRESS <u>9609 Bristol Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Charlotte</u> Middle <u>May</u> Last <u>Pagioli</u>		4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>CAUC</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/6/1907</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DC</u>	
11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick Hardy</u>		14. MOTHER'S MAIDEN NAME <u>Susie Steele</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hosp records</u>	
17. INFORMANT Address <u>Hosp records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Lesion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hemorrhage from Varicella</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>3-4 yrs</u> <u>10 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 4</u> 1954, to <u>May 7</u> 1957, that I last saw the deceased alive on <u>May 7</u> 1957, and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.B. Wardrop</u> M.D.		ADDRESS (Street, city or town, state) <u>837 Bonifant St, Silver Spring, Maryland</u> DATE SIGNED <u>5/7/57</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Wardrop, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5-10-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MOUNT OLIVET CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter W. Nepongle</u> ADDRESS <u>1300-N St NW</u>		24a. REC'D BY REGISTRAR <u>J. Thelma Dodds</u> DATE <u>5/10/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>J. Thelma Dodds</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 10 1957

RECEIVED

RECEIVED MAY 10 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05418

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05397

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Echo</b>		c. LENGTH OF STAY IN lb <b>appr. 5 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>McArthur Blvd</b>				d. STREET ADDRESS <b>3653 Minnesota Ave. S. E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sr. John Howard POLLET</b>				4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <del>MARRIED</del> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <del>WIDOWED</del> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 19, 1893</b>		9. AGE (In years (if birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> IF UNDER 24 HRS. Hours <b>7</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer - Concrete Op.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cramer Construc.</b>		11. BIRTHPLACE (State or foreign country) <b>Milwaukee, Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-18-7464</b>		17. INFORMANT <b>John H. Pollet, Jr.</b> Address <b>4330 Duke St. Alexandria, Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Frank J. Broschart, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>May 29, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>5-29-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>W. W. Chambers</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>				ADDRESS <b>7557 Wood Ave. N.W.</b>		24a. REC'D BY REGISTRAR <b>JUN 2 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>L. H. Schmitt</b>			

RECEIVED  
JUN 3 1957  
STANDARD & S.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05419

CERTIFICATE OF DEATH

05398

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg - Route 1</i>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Burnham Road</i>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Norris</i> Last <i>Prather</i>		4. DATE OF DEATH Month <i>May</i> Day <i>3</i> Year <i>1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 13-1874</i>
9. AGE (In years last birthday) <i>82</i> yrs.		10. IF UNDER 1 YEAR Months <i>8</i> Days <i>28</i> IF UNDER 24 HRS Hours <i></i> Min <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Taylorville, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wesley Prather</i>		14. MOTHER'S MAIDEN NAME <i>Alice Dickinson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Katie Emma Prather</i> Address <i>Gaithersburg, Md.</i>		R-1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute heart failure</i> 4 DUE TO <i>Chronic myocardial degeneration</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Senility</i> (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH <i>10-15 minutes</i> <i>3 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> o. m. <i></i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April - 26 - 1957</i> to <i>May - 3 - 1957</i> , that I last saw the deceased alive on <i>April - 26 - 1957</i> , and that death occurred at <i>12 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William C. Miller</i> M.D.		ADDRESS (Street, city or town, state) <i>7-Brooks Ave</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i>		<i>Gaithersburg, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>MAY 6/1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>BROOK GROVE</i>	22d. LOCATION (City, town, or county) (State) <i>Montgomery Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ray W. Pearson</i> ADDRESS <i>Taylorville, Md</i>		24a. REC'D BY REGISTRAR <i>May 7-57</i>	24b. REGISTRAR'S SIGNATURE <i>Charles L. Cook</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 10 1957

BUREAU V. S.

WILLIAM C. MILLER  
WILLIAM D. MILLER  
MAY - 25 - 57

2-6-57  
MAY - 25 - 57  
MAY - 25 - 57

Acute heart failure  
Chronic myocardial degeneration  
3-1-57  
12-12-57

WILLIAM C. MILLER  
WILLIAM D. MILLER  
MAY - 25 - 57  
MAY - 25 - 57  
MAY - 25 - 57

WILLIAM C. MILLER  
WILLIAM D. MILLER  
MAY - 25 - 57  
MAY - 25 - 57  
MAY - 25 - 57

WILLIAM C. MILLER  
WILLIAM D. MILLER  
MAY - 25 - 57  
MAY - 25 - 57  
MAY - 25 - 57

05420

CERTIFICATE OF DEATH

05399

Reg. Dist. No. -78

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GERMANTOWN</b>				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MARYLANDER REST HOME</b>				d. STREET ADDRESS <b>GERMANTOWN</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALICE HILDA PRICE</b>		4. DATE OF DEATH Month Day Year <b>5 14 1957</b>					
5. SEX <b>FEM</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-13-1892</b>	9. AGE (In years last birthday) <b>65</b> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MONTGOMERY CO.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>NATHAN KINNA</b>				14. MOTHER'S MAIDEN NAME <b>JANE PICKENS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>RAYMOND P. PRICE HYATTSTOWN MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of colon with generalized metastases</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Feb 14</b> , 19 <b>56</b> , to <b>May 14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 14</b> , 19 <b>57</b> , and that death occurred at _____, from the causes and on the date stated above							
ACTUAL SIGNATURE <b>James P. Kinn</b> M.D.				ADDRESS (Street, city or town, state) <b>Hyattstown, Md.</b> DATE SIGNED <b>5/15/57</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>5-17-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>HYATTSTOWN METHODIST</b>		22d. LOCATION (City, town, or county) (State) <b>HYATTSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. L. Burdette</b> ADDRESS <b>Hyattstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>5/16/57</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Burdette</b>	

BUREAU V. E.

MAY 18 1957

RECEIVED

05421

## CERTIFICATE OF DEATH

05400

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>17 hr. 54 min.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>Wilcove Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>PRUE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 May 1957</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Chester Devond Prue</b>		14. MOTHER'S MAIDEN NAME <b>Christine Julia Baker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		17. INFORMANT <b>(Father) Chester D. Prue (Same As 13)</b>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b) and, (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uyaline membrane disease</b> <b>770.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemolytic Disease of Newborn (Rh incompatibility)</b> DUE TO (c) <b>Prematurity - 33 weeks</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b> <b>18 hours</b> <b>18 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4 May</b> , 19 <b>57</b> , to <b>5 May</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5 May</b> , 19 <b>57</b> , and that death occurred at <b>4:55 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 5-6-57</b>			
ACTUAL SIGNATURE <b>John H. Mazur</b>		M.D. <b>U.S. Naval Hospital, Bethesda, Md. 5-6-57</b>	
PHYSICIAN'S NAME (Type) <b>John H. Mazur, LT, MC, USN</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>buried</b>	22b. DATE THEREOF <b>5-8-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Mazur</b>		ADDRESS <b>1501 Wisconsin Ave., Bethesda, Md.</b>	24a. REC'D BY REGISTRAR <b>5-6-57</b>
		24b. REGISTRAR'S SIGNATURE <b>Betty E. Cassel</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 8 1957

RECEIVED

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05401

05422

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westmoreland Hills Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>	
c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>		d. STREET ADDRESS <u>22 Bellfield Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5408 Albemarle St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Blandine</u> Middle <u>Blandford</u> Last <u>Ramage</u>		4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 2 1869</u>
9. AGE (In years last birthday) <u>87</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Prince Geo. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Joseph C. Ramage</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Robert C. McCann</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331x cerebral vascular accident</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple strokes 2 yrs - congestive heart failure</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>454 i</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 27</u> , 19 <u>57</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jackson M. Arlen</u> M.D.		ADDRESS (Street, city or town, state) <u>5404 Albemarle Wash DC</u>	
PHYSICIAN'S NAME (Type) <u>May 29 '57</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 31-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Alexandria Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Demaine Jr.</u>		ADDRESS <u>Alex. Va.</u>	
24a. REC'D BY REGISTRAR <u>DATE 5-31-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

RECEIVED

JUN 4 1957

BUREAU V. S.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-3. BM-3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 shall be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 05423									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>6 1/2</u> hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>National Institute of Health</u>					d. STREET ADDRESS <u>8608 Brandt Place</u>				
3. NAME OF DECEASED (Type or print) <u>Sheldon</u> <u>Edward</u> <u>Reaume</u>					4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1957</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>May 6, 1922</u>		9. AGE (In years last birthday) <u>35</u> yrs.	
						IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Micro biologist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Mich.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown Reaume</u>					14. MOTHER'S MAIDEN NAME <u>Emma M. ?</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>??</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cyanide poisoning (suicide)</u> <u>11.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 6, 1957</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>5/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>			22d. LOCATION (City, town, or county) (State) <u>Prince Georges Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis.Ave.Bethesda Md.</u>						24a. REC'D BY REGISTRAR <u>1/157</u>		24b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	

BUREAU V. S.

MAY 20 1957

RECEIVED

## 05424 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANN ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. COUNTY <u>ANN ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>				c. LENGTH OF STAY IN 1b <u>4 mos. 21 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>233 Varnum St., N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Benedict</u> Last <u>RUBIEL Jr.</u>				4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 Feb. 1893</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Commercial</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Benedict Riedel, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Euphasia Oswald</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>(son) Robert Benedict Riedel, III (same as 13)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>arteric stenosis and mitral insufficiency</u> DUE TO (c) <u>Rheumatic Heart Disease, Inactive</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>1-2 years</u> <u>1-2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>16X</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>  </u>		(County) <u>  </u>		(State) <u>  </u>
21. I certify that I attended the deceased from <u>17 Dec.</u> , 19 <u>56</u> , to <u>9 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9 May</u> , 19 <u>57</u> , and that death occurred at <u>7:10 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u>						DATE SIGNED <u>5-10-57</u>	
ACTUAL SIGNATURE <u>Thomas R. Ulshafer</u>		M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>					
PHYSICIAN'S NAME (Type) <u>Thomas R. Ulshafer, CDR, MC, USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-13-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Johntown, Pennsylvania</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Miller</u>		ADDRESS <u>WASH. D. C.</u> <u>4 Carroll Ave., N.W.</u>		24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Parselley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

MAY 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05315

CERTIFICATE OF DEATH

05404

Reg. Dist. No. 53

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Rockville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>204 Maryland Ave.</b>				d. STREET ADDRESS <b>204 Maryland Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>EZRA</b> Middle <b>ROYER</b> Last <b>ROYER</b>				4. DATE OF DEATH Month <b>May</b> Day <b>15</b> , 1957 Year <b>19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/29/69</b>	9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months <b>4</b> Days <b>18</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>		11. BIRTHPLACE (State or foreign country) <b>Westminister, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>John Royer</b>				14. MOTHER'S MAIDEN NAME <b>Martha Royer- Item # 2</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-12-7579</b>		17. INFORMANT <b>Martha Royer- Item # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>446X</b> DUE TO <b>premia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis + chronic nephritis</b> DUE TO <b>5 yrs.</b> (c) <b>none.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> , 19 <b>May 15</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 15</b> , 19 <b>57</b> , and that death occurred at <b>6:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>26 N. Summit Ave.</b> DATE SIGNED <b>May 16, 1957</b> ACTUAL SIGNATURE <b>Wm. A. Linticium</b> M.D. <b>Wm. A. Linticium, M.D.</b> PHYSICIAN'S NAME (Type) <b>Wm. A. Linticium</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/19/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadow Branch</b>		22d. LOCATION (City, town, or county) (State) <b>Westminister, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>5/20/57</b>	
						24b. REGISTRAR'S SIGNATURE <b>Travis Page</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

MAY 20 1957

RECEIVED

05425

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A.F.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Md., Bethesda, Md.</b>		d. STREET ADDRESS <b>501 Poplar Street</b>	
3 NAME OF DECEASED (Type or print) First <b>Judy</b> Middle <b>FRANCINE</b> Last <b>ROYLANCE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-24-13</b>
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Territory of Hawaii</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>Vaun R. Roylance</b>		14 MOTHER'S MAIDEN NAME <b>Rose Mildred Wierhos</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17 INFORMANT (Father) <b>Vaun R. Roylance</b> Address <b>(Same Ad.)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute lymphocytic leukemia</b> <b>204.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2 May</b> , 19 <b>57</b> , to <b>15 May</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>15 May</b> , 19 <b>57</b> , and that death occurred at <b>4:29 A.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>J. S. Dunn, Jr.</b> M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>		DATE SIGNED <b>5-15-57</b>	
PHYSICIAN'S NAME (Type) <b>T.S. Dunn, Jr., LL, MC, JCN</b>		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>5-17-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Annapolis Nat'l Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor, Sons</b> ADDRESS <b>1111 1/2 St. S.E., Annapolis, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>5-15-57</b> 24b. REGISTRAR'S SIGNATURE <b>Wray E. Carrelly</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 17 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05426

## CERTIFICATE OF DEATH

05406

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTG</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTG</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
c. LENGTH OF STAY IN 1b <u>7 days</u>				d. STREET ADDRESS <u>3500 Raymond ST</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Ruthven</u> Last <u>Ruthven</u>				4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-27-70</u>	
9. AGE (In years last birthday) <u>86</u> yrs		10. UNDER 1 YEAR Months <u>10</u> Days <u>19</u> Hours <u>57</u> Min.		11. BIRTHPLACE (State or foreign country) <u>CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (Accountant) Armour &amp; Company</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Armour &amp; Company</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Obstructive jaundice + Hemorrhagic gastritis</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma, head of pancreas</u> DUE TO (c) <u>2 weeks</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemorrhagic cystitis, with calculus</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APR 6, 1957</u> , to <u>MAY 10, 1957</u> , that I last saw the deceased alive on <u>MAY 10, 1957</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. W. E. DeLauter, M.D.</u>				ADDRESS (Street, city or town, state) <u>8025 ABERDEEN RD Bethesda 14, Md</u>		DATE SIGNED <u>5/10/57</u>	
PHYSICIAN'S NAME (Type) <u>DEWITT E DELAUTER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery Prince Georges County Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company</u>				ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>5/13/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Beauregard Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

MAY 13 1957

RECEIVED

05427

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a STATE <b>Virginia</b> b COUNTY <b>Henrico</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>		c LENGTH OF STAY IN 1b <b>225 days</b>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Richmond</b>	
d STREET ADDRESS <b>5211 Bloomingdale Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Russell</b> Middle <b>Seward</b> Last <b>Samuel</b>		4. DATE OF DEATH Month <b>May</b> Day <b>15</b> , Year <b>1957</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>November 11, 1905</b>
9. AGE (In years lost birthday) yrs <b>51</b>		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cleaning</b>	
11 BIRTHPLACE (State or foreign country) <b>Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas A. Samuel</b>		14 MOTHER'S MAIDEN NAME <b>Sadie Watts</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>No</b>		16 SOCIAL SECURITY NO <b>unknown</b>	
17 INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent carcinoma of the mouth</b> <b>144X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I attended the deceased from <b>October 2, 1956</b> to <b>May 15, 1957</b> , that I last saw the deceased alive on <b>May 15, 1957</b> , and that death occurred at <b>1:05 P.</b> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <b>Martin E. Liebling</b> M.D.		<b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>MARTIN E. LIEBLING, M. D.</b>			
22a BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>May 16, 1957</b>		<b>Richmond VA</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Tatham</b>		ADDRESS <b>3619-14th St NW</b>	24a REC'D BY REGISTRAR DATE <b>MAY 17 57</b>
		24b REGISTRAR'S SIGNATURE <b>Benjamin Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 17 1957

RECEIVED

05428

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>District of Columbia</u> b. COUNTY <u>LA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>2300 Texas Ave., S.E.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>Charmaine</u> Middle <u>(n)</u> Last <u>SAVAGE</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>19 57</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>30 April 1957</u>	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>5</u> Hours <u>5</u> Min.		
10a USAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13 FATHER'S NAME <u>Sylvester James Savage</u>				14. MOTHER'S MAIDEN NAME <u>Shirley Frances Gibson</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOC AL SECURITY NO <u>None</u>		17. INFORMANT <u>(Father) Sylvester J. Savage (Same as Pa.)</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prematurity (under 1000 grams)</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>                    </u> DUE TO (c) <u>                    </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3</u>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>                    </u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f (City or town)		20g (County)		20h (State)			
21. I certify that I attended the deceased from <u>30 April</u> , 19 <u>57</u> , to <u>2 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2 May</u> , 19 <u>57</u> , and that death occurred at <u>11:20 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>George J.A. Magnant</u>		M.D. <u>U.S. Naval Hospital, Bethesda, Md. 5-3-57</u>					
PHYSICIAN'S NAME (Type) <u>George J.A. Magnant, LL.M.C., U.S.N.</u>		U.S. Naval hospital, Bethesda, Md.					
22a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-7-57</u>		22c NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>			
22d LOCATION (City, town, or county) <u>Arlington, Va.</u>		22e (State) <u>VA.</u>		22f (Country) <u>U.S.A.</u>			
23. FURNERAL DIRECTOR'S NAME <u>Funeral Home, 1722 7th St., N.W.</u>		ADDRESS <u>Washington, D.C.</u>		24a REC'D BY REGISTRAR DATE <u>5-3-57</u>			
24b REGISTRAR'S SIGNATURE <u>May E. Russell</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

MAY 6 1957

RECEIVED

05302

## CERTIFICATE OF DEATH

Reg. Dist. No.

05409  
773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>8 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Schaub</u>				4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-5-30</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>William H. Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Stillwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>-----</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor (osteoma)</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs ±</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>57</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>4-28</u> 19 <u>57</u> , to <u>5-3</u> 19 <u>57</u> , that I last saw the deceased alive on <u>5-2</u> 19 <u>57</u> , and that death occurred at <u>253A</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>1726 M St NW, DC</u> DATE SIGNED <u>5-3-57</u>							
ACTUAL SIGNATURE <u>Jonathan M Williams</u>							
PHYSICIAN'S NAME (Type) <u>  </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/6/57</u>		<u>Rock Creek Cemetery</u>		<u>Washington, DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Funeral Home</u> ADDRESS <u>3605-14 St NW</u>							
24a. REC'D BY REGISTRAR <u>MAY 6 1957</u> 24b. REGISTRAR'S SIGNATURE <u>J. H. ...</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

MAY 6 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 05303 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05410

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring Takoma Park</b>			c. LENGTH OF STAY IN 1b <b>1 hr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wash. San. and Hosp.</b>				d. STREET ADDRESS <b>410 Sligo Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Edward</b> Last <b>Scheer</b>				4. DATE OF DEATH Month <b>May</b> Day <b>11</b> , Year <b>1957</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/29/74</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b>		IF UNDER 24 HRS. Hours <b></b> M.in. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Scheer</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth (Unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hosp. Record</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>812X</b> DUE TO <b>Fracture of Skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hr. 17 m.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Pedestrian - Struck by car while crossing Street</b>					
20c. TIME OF INJURY <b>11</b> Hour <b>5/11/57</b> o. m. <b>3:00</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>		20f. (City or town) (County) (State) <b>Silver Spring, Montg Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 13, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Rood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter E. Pumphrey</b>				ADDRESS <b>Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>5/20/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>J. McKen Dadd</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 21 1957

RECEIVED

05304

## CERTIFICATE OF DEATH

Reg. Dist. No.

05411

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tobacco Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural #2 Bridgeville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hospital</u>				d. STREET ADDRESS <u>R.D. #2 Box 91</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles (NAN) Smith</u>				4. DATE OF DEATH Month Day Year <u>May 2 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27 1878</u>	9. AGE (In years last birthday) <u>78</u> yrs	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Smith</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Grising</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Patent's Chart</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prostatic Hypertrophy, Carcinoma</u> DUE TO <u>Surgical Shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last (b) <u>Carcinoma of Melanosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Surgery</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>April 28 1957</u> to <u>May 3 1957</u> , that I last saw the deceased alive on <u>May 3 1957</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Oliver E. Thompson</u> M.D.				ADDRESS (Street, city or town, state) <u>1835 Eye St. Wash DC.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>OLIVER E. THOMPSON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>MAY 4 - 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ST. JOHN'S, PENNA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.A. WALTERS</u> ADDRESS <u>254 CARROLL ST. Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>5/14/57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 6 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05412	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 218	
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg RFD</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg RFD</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Jones Lane</b>					d. STREET ADDRESS <b>Jones Lane</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>Smith</b> Last					4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>1957</b>						
5. SEX <b>male</b>		6. COLOR OR RACE <b>col.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>unknown</b>		9. AGE (In years last birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b> Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Samuel Smith</b>					14. MOTHER'S MAIDEN NAME <b>Margaret Cooper</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT			Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> DUE TO <b>922.0</b> Conditions, if any, which gave rise to immediate cause (b) <b>Alcoholism</b> (c) <b>Alcoholism</b> DUE TO <b>Alcoholism</b> cause lost. INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>24 hrs.</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Aspiration of Blood</b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Either fell or was beaten about face</b>								
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>5/19</b> 1957 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Gaithersburg Montg. Maryland</b>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			<b>5/22/1957</b>			
22a. BURIAL, CREMATION, REBURYAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/23/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Quince Orchard,</b>			22d. LOCATION (City, town, or county) (State) <b>Quince Orchard, Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert R. Swonder</b> ADDRESS <b>Rockville, Md.</b>					24a. REC'D BY REGISTRAR <b>MAY 27 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Robert R. Swonder</b>				

BUREAU V. S.

MAY 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05413

05430

## CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barnesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barnesville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Harris</b> Last <b>Stonestreet</b>		4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 14-1905</b>
9. AGE (In years last birthday) <b>51</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired auditor of</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>milk producers assoc. Maryland</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Dr. Joseph H. Stonestreet</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Wood</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>577-03-3310</b>	
17. INFORMANT <b>Mrs Harris Stonestreet, Barnesville Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Hemorrhage</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Far-advanced Pulmonary tuberculosis</b> DUE TO (c) <b>104 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>11 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>50</b> to <b>24 May</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>24 May</b> , 19 <b>57</b> , and that death occurred at <b>9:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edwin M. Smith</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Barnesville, Md. 24 May 57</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 27-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>	22d. LOCATION (City, town, or county) (State) <b>Beallsville</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Hilde</b>		ADDRESS <b>Barnesville Md</b>	
24a. REC'D BY REGISTRAR <b>5/27/57</b>		24b. REGISTRAR'S SIGNATURE <b>Charles W. Elgin</b>	

RECEIVED

MAY 29 1957

BUREAU V. 4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05431

CERTIFICATE OF DEATH

05414

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>2 hrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>				e. STREET ADDRESS <b>Rt. #1</b>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Strickland</b> Last <b>Strickland</b>				4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/8/57</b>	9. AGE (In years last birthday) yrs. <b>2</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min <b>2</b>	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Harold Wade Strickland</b>			
14. MOTHER'S MAIDEN NAME <b>Ellen Mary Smith</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Father</b> Address <b>Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Apoplexsis</b> DUE TO (b) <b>Immaturity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>5-8-57</b> , 19 <b>57</b> , to <b>5-8-57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5-8-57</b> , 19 <b>57</b> , and that death occurred at <b>9:35A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. A. Yates</b> M.D.				ADDRESS (Street, city or town, state) <b>Olney, Md.</b>			
PHYSICIAN'S NAME (Type) <b>R. A. Yates, M. D.</b>				DATE SIGNED <b>5-8-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/9/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter E. Humphrey</b>				24a. REC'D BY REGISTRAR <b>5-10-57</b>			
24b. REGISTRAR'S SIGNATURE <b>Katherine B. Jarrow</b>				24c. REGISTRAR'S NAME <b>Katherine B. Jarrow</b>			

BUREAU V. 81

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05432

CERTIFICATE OF DEATH

05415  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>50 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				e. STREET ADDRESS <b>6 7816 Tilbury Street</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Roger</b> Middle <b>"J"</b> Last <b>SUTTON</b>				4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 June 1918</b>		9. AGE (In years last birthday) <b>38</b> yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Nelson Sutton</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Rogers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 5-25-42 to 5-26-57</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Official Navy Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intra cerebral hemorrhage</b> DUE TO <b>Thrombocytopenia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Aplastic anemia</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6 April</b> , 19 <b>57</b> , to <b>26 May</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>26 May</b> , 19 <b>57</b> , and that death occurred at <b>5:50 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>5-27-57</b>							
ACTUAL SIGNATURE <b>Russell Miller, Jr.</b>				PHYSICIAN'S NAME (Type) <b>Russell Miller, Jr. LT, MC, USN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>5-31-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Private Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Peoria, Illinois</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				24a. REC'D BY REGISTRAR <b>R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Tarsally</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
MAY 29 1957  
BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Form 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 05416										
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c. LENGTH OF STAY IN 1b <b>3 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8201 Grubb Road, Apt. 201</b>					d. STREET ADDRESS <b>8201 Grubb Rd., Apt. 201</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Alphonse</b> Middle <b>Swegon</b> Last					4. DATE OF DEATH <b>May</b> Month <b>March 28</b> Day <b>19 57</b> Year					
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 2, 1906</b>		9. AGE (In years last birth day) <b>50</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Inspector, Dept. Public Works, D.C.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Glen Burnie, Md.</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>Martin Swegon</b>					14. MOTHER'S MAIDEN NAME <b>Anna Dzinnek</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>215-01-6503</b>		17. INFORMANT <b>Mrs. Dorothy Swegon, 8201 Grubb Rd., SS., Md.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>420.1</b> (c), stating the underlying cause lost. DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>sudden</b>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <b>Frank J. Broschart</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-1-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Italy Mason</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>					ADDRESS <b>5305 Harford</b>		24a. REC'D BY REGISTRAR <b>MAY 31 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Francis</b>	

MEDICAL CERTIFICATION

RECEIVED

MAY 31 1957

BUREAU V. S.

## 05305 CERTIFICATE OF DEATH

05417

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY <b>PICKENS</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GREENVILLE</b>	
c. LENGTH OF STAY IN 1b <b>26 days</b>		d. STREET ADDRESS <b>400 Belmont Ave</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium Hosp</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRED</b> Middle <b>William</b> Last <b>SYMMES</b>		4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1879</b>
9. AGE (In years last birthday) <b>77 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min. <b>7</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>Amec.</b>	
13. FATHER'S NAME <b>Whitner Symmes</b>		14. MOTHER'S MAIDEN NAME <b>Nettie Alexander</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>NO</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b> <b>400.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coronary Insufficiency</b> DUE TO (c) <b>Hypertensive C-V disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>Recent</b> <b>? years</b> <b>? years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cholelithiasis &amp; Gastric Congestion</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/27, 1957</b> , to <b>5/23, 1957</b> , that I last saw the deceased alive on <b>5/22/1957</b> , and that death occurred at <b>5:14 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert A. Hare</b> M.D.		ADDRESS (Street, city or town, state) <b>Takoma Park, Md</b>	
DATE SIGNED <b>5/23/57</b>			
PHYSICIAN'S NAME (Type) <b>Robert A. Hare</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 23, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Springwood</b>	22d. LOCATION (City, town, or county) (State) <b>Greenville, South Carolina</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph E. Hare</b>		ADDRESS <b>1756 Pine Avenue</b>	
24a. REC'D BY REGISTRAR <b>5/24/57</b>		24b. REGISTRAR'S SIGNATURE <b>J. McDonald</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 27 1957

BUREAU V. E.



05434 CERTIFICATE OF DEATH

05418  
Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Georgia</b> b. COUNTY <b>Nicholls</b>	
c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nicholls</b>	
d. NAME OF HOSPITAL (If not in hospital, give address) OR INSTITUTION <b>The Clinical Center National Institutes of Health, Bethesda, Md.</b>		d. STREET ADDRESS <b>Route # 2</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Margaret Tanner</b>		4. DATE OF DEATH Month Day Year <b>May 1 19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 June 1924</b>
9. AGE (in years last birthday) <b>32</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telegraph Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Communications</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clifton Rowell</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Anderson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not available</b>	
17. INFORMANT <b>The Medical Record, Clinical Center National Institutes of Health, Bethesda 14, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory insufficiency, acute, due to chronic + pulmonary congestion</b> DUE TO <b>Carcinoma, metastatic to lungs, liver, skeleton, neck, region</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>neck, region</b> DUE TO (c) <b>neck, region</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 mos.</b> <b>Respirable</b> <b>? several weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 29, 19 57</b> , to <b>May 1, 19 57</b> , that I last saw the deceased alive on <b>May 1, 19 57</b> , and that death occurred at <b>9.20 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>5/2/57</b>			
ACTUAL SIGNATURE <b>Peter D. Olch</b>		M.D. <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Peter D. Olch, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit 5/2/57</b>	22b. DATE THEREOF <b>5/2/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Forest Grove Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Coffee County, Georgia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>5-8-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 6 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PA3. Page 5 may be retained for your files. For: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

05435

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05419

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>		5. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10,229 Green Forest Drive</b>				d. STREET ADDRESS <b>10,229 Green Forest Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Raymond James Teachey</b>				4. DATE OF DEATH <b>May 19 19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 9, 1902</b>		9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Supt., Hall Construction Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Rose Hill, N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William W. Teachey</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-12-9901</b>		17. INFORMANT <b>Mrs. Nina M. Teachey, 10,229 Green Forest Dr.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<b>May 19, 1957</b>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		22b. DATE THEREOF <b>5/22/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter S. Humphrey</b>				ADDRESS <b>Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>5/24/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Frances Carter</b>			

BUREAU V. S.

NOV 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05436 CERTIFICATE OF DEATH

05420

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived f. institution. Reside before admiss on) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (f. outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>49 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>3416 Tulane Drive</b>	
3 NAME OF DECEASED (Type or print) First <b>Jewell</b> Middle <b>Elizabeth</b> Last <b>Thielking</b>		4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>57</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>December 18, 1904</b>
9 AGE (In years lost birthday) <b>52 yrs</b>		F UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School Teacher</b>	11 BIRTHPLACE (State or foreign country) <b>Tennessee</b>
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13 FATHER'S NAME <b>Joseph H. Davis</b>	
14 MOTHER'S MAIDEN NAME <b>Mary Langford</b>		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16 SOCIAL SECURITY NO <b>525-82-8539</b>		17 INFORMANT <b>The Medical Record</b> address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Cervix with spread to</b> <b>171X</b> <b>Small and large bowel and all pelvic organs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Severe bilateral pneumonia into adenoid glands</b> (c) <b>pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>445</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 13, 1957</b> to <b>May 1, 1957</b> , that I last saw the deceased alive on <b>May 1, 1957</b> , and that death occurred at <b>10.50 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
ACTUAL SIGNATURE <b>Allan H. Levy</b> M.D.		PHYSICIAN'S NAME (Type) <b>Allan H. Levy</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>TRANS. &amp; BURIAL</b>	<b>5/4/57</b>	<b>WHITE ROSE CEMETERY</b>	<b>GIBSON, TENNESSEE</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b> ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REG. STRAR <b>DATE 5-3-57</b>	24b. REGISTRAR'S SIGNATURE <b>Beattie M. Thompson</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

BUREAU V. 8

MAY 6 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>Montg</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montg</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				d. STREET ADDRESS <b>2713 Emmet Road</b>			
3. NAME OF DECEASED (Type or print) <b>Grover</b>		First <b>Frances</b>		Middle <b>Tolson</b>		Last <b>May</b>	
5 SEX <b>Male</b>		6. COLOR OR RACE <b>caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-7-'3</b>	
9 AGE (In years last birthday) <b>73</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Julius Tolson</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>hospit:l records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 yrs</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>XX</b> <b>Uremia Diabetes</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 5, 1957</b> , to <b>May 6, 1957</b> , that I last saw the deceased alive on <b>May 5, 1957</b> , and that death occurred at <b>8:20 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George Sharpe</b>		M.D. <b>10511 Summit Ave</b>		DATE SIGNED <b>5/6/57</b>			
PHYSICIAN'S NAME (Type) <b>George Sharpe M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-9-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Smithland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Lees Sons</b>		ADDRESS <b>Wash. D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>5-8-57</b>		24b. REGISTRAR'S SIGNATURE <b>Beattie M. Thompson</b>	

BUREAU V. E.

MAY 10 1957

RECEIVED



## 05438 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE <b>West Virginia</b> b COUNTY			
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c LENGTH OF STAY IN 1b <b>84 days</b>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>				e STREET ADDRESS <b>(No street address)</b>			
3. NAME OF DECEASED (Type or print) First <b>Felice</b> Middle <b>-</b> Last <b>Tori</b>				4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>19 57</b>			
5 SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>7 October 1891</b>	
9 AGE (In years last birthday) <b>65</b> yrs		IF UNDER 1 YEAR: Months <b>65</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		IF UNDER 24 HRS: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mine Worker</b>				10b KIND OF BUSINESS OR INDUSTRY <b>Coal Mining</b>		11 BIRTHPLACE (State or foreign country) <b>Italy</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Italy</b> ✓							
13 FATHER'S NAME <b>Celerte Tori</b>				14 MOTHER'S MAIDEN NAME <b>Matilda Cescini</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)				16 SOCIAL SECURITY NO <b>236-12-4863</b>		17 INFORMANT <b>The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent Carcinoma of Face &amp; Neck</b> 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>at least 8 months.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>525X Pulmonary fibrosis</b>							
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>February 12, 19 57</b> , to <b>May 7, 19 57</b> , that I last saw the deceased alive on <b>May 7, 19 57</b> , and that death occurred at <b>9:25 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>							
22. ACTUAL SIGNATURE <b>Chester Z. Haverback, M.D.</b> DATE SIGNED <b>5/9/57</b>							
PHYSICIAN'S NAME (Type) <b>Chester Z. Haverback, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
22b. DATE THEREOF <b>5/10/57</b>							
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet</b>							
22d. LOCATION (City, town, or county) (State) <b>Kanawha Co., W. Virginia</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS							
24a. REC'D BY REGISTRAR <b>5-10-57</b> 24b. REGISTRAR'S SIGNATURE <b>Bernie M. Thompson</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

1 1957

RECEIVED

05439

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (local)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 47 X 3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>2123 California Ave., N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ethel</b> Middle <b>Hartson</b> Last <b>TURNER</b>		4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 December 1881</b>
9. AGE (In years last birthday) <b>75</b> yrs		IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>California</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Burnell Hartson</b>		14. MOTHER'S MAIDEN NAME <b>Anne Gluyas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Daughter, Anne T. Henry, Bryan Road, Fawcett,</b>		Address <b>Connecticut</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Branchiopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebrovascular Accident</b> DUE TO <b>11 days</b> (c) <b>Generalized Arteriosclerosis</b> DUE TO <b>10+ yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5-6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>29 April</b> 19 <b>57</b> to <b>5 May</b> 19 <b>57</b> , that I last saw the deceased alive on <b>4 May</b> 19 <b>57</b> , and that death occurred at <b>3:31 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>5-5-57</b>			
ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>L. S. DUNN, JR., LT, MC, USN</b> <b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-9-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE & ADDRESS <b>[Signature]</b> <b>Funeral Home, 2200 Penn. Ave., N.W., Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE 5-6-57</b>	24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

MAY 1947

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05424

05440

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN HOSPITAL</b>				d. STREET ADDRESS <b>10,407 BRUNSWICK AVENUE</b>			
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>BURTON</b> Last <b>VIGRASS</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>28</b> Year <b>1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/15/05</b>		9. AGE (In years last birthday) <b>51</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRINTER - Washington Post Newspaper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>ERIE, PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EARNEST VIGRASS</b>				14. MOTHER'S MAIDEN NAME <b>EFFA ANN KENDALL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Ellen B. Vigrass, 10,407 Brunswick Ave. Silver Spring, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>754.2 Congestive Heart Failure</b> DUE TO (b) <b>Emphysema and Asthma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>30 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/18/55</b> 19 to <b>5/28/57</b> 19, that I last saw the deceased alive on <b>5/28/57</b> 19, and that death occurred at <b>2:10 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John J. Curry, M.D.</b>				ADDRESS (Street, city or town, state) <b>10620 Georgia Ave 5/28/57</b>			
PHYSICIAN'S NAME (Type) <b>JOHN J. CURRY</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/31/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGE COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>DATE 5-31-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

RECEIVED

JUN 4 1957

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detailed for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05425

Item 9 FilmG216 6-3-57 et

## 05306 CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Tokama Park</u>		<u>10 - Months</u>		TOWN <u>Cherry Chase</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cedar Haven Rest Home</u>				STREET ADDRESS (If rural give location) <u>4805 - Solstone ST.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Bessie M Walker</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 22 19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 7 18 71</u>	9. AGE last birthday <u>84 85</u> yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Fridley</u>				14. MOTHER'S MAIDEN NAME <u>Saddler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Rest Home Leckords</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
430.0 IMMEDIATE CAUSE (A) <u>Pulmonary edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>congestive heart failure</u>				<u>6+ months</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>arteriosclerotic heart disease</u>				<u>15+ years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>mass in ABDOM (cause undetermined)</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1 AUG. 19 56</u> , to <u>5 / 22 19 57</u> , that I last saw the deceased alive on <u>5 / 24</u> , 19 <u>57</u> , and that death occurred at <u>8:55 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Haversch</u>				DATE SIGNED <u>5/24/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-24-57</u>		NAME OF CEMETERY OR CREMATORY <u>Blonwood</u>		LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
24. REC'D BY REGISTRAR <u>5/24/57</u>		REGISTRAR'S SIGNATURE <u>J. Wilson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm. Lee</u>		ADDRESS <u>son's - 700 - 4th ST. N.E. Wash. D.C.</u>	

RECEIVED

MAY 27 1957

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 05441 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05426

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8807 Plymouth St</u>				d. STREET ADDRESS <u>1 8807 Plymouth St</u>			
3. NAME OF DECEASED (Type or print) First <u>Conrad</u> Middle <u>Wallert</u> Last <u></u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-15-1899</u>	
9. AGE (in years last birthday) <u>58</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Drew Wallert</u>		Address <u>3925 Davis Pl N.W. Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>							
420.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u>							
DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>25 yrs</u>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Wanjansley + Ans - 3501 14th St. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>5/21/57</u>		24b. REGISTRAR'S SIGNATURE <u>Frances</u>	

MEDICAL CERTIFICATION

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please state the cause of the delay. The certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Medical Examiner's Office along with form FWS. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. E.

MAY 24 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal, cremation, or removal.

05442

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05427

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Ma.</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown R 2</b>				c. LENGTH OF STAY IN 1b <b>Found dead</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hughston E. Downs Farm Seneca Rd.</b>				d. STREET ADDRESS <b>Violet Lock Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Homer</b> Middle <b>Lincoln</b> Last <b>Washington</b>				4. DATE OF DEATH Month <b>May</b> Day <b>14</b> Year <b>1957</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>col.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 1, 1899</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer- farm</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Bertha Preston 1411 Harvard St. N.W. D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Found dead in barn</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Had been dead two or three days when found</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> %/15/57			
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF <b>5/15/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Goplar Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Southwings, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>				ADDRESS <b>Rockville, Md.</b>			
24a. REC'D BY REGISTRAR DATE <b>7/17/57</b>		24b. REGISTRAR'S SIGNATURE <b>Edw. A. Carter</b>					

BUREAU V. B.

MAY 17 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05443

CERTIFICATE OF DEATH

05428 16

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland,</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				d. STREET ADDRESS <b>4730 Bradley Blvd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Nancy</b> Middle <b>Parker</b> Last <b>Weiss</b>				4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17, 1883</b>		9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia, King George Co.</b>	
13. FATHER'S NAME <b>Walter Coakley</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
14. MOTHER'S MAIDEN NAME <b>Annie M. Fogg</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>-----</b>				17. INFORMANT Address <b>Chevy Chase, Md.</b> <b>Mrs. Annie B. Price, 4730 Bradley Blvd.,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Extensive Confluent Broncho-500X</b> DUE TO (b) <b>pneumonia Right lung -</b> DUE TO (c) <b>Marked Tracheobronchitis.</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anteriorly occluded heart disease -</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>April, 1957</b> , to <b>5/18, 1957</b> , that I last saw the deceased alive on <b>5/17, 1957</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles Savaris Jr</b> M.D.				ADDRESS (Street, city or town, state) <b>4861 Kathy Lane Bethesda, Md.</b>			
DATE SIGNED <b>5/18/57</b>							
PHYSICIAN'S NAME (Type) <b>CHARLES J. SAVARIS JR</b>							
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF <b>5/21/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Myer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bethesda, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Martin W. Hyungco</b>				ADDRESS <b>1300 N. 1st St. Washington D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie Thompson</b>	
24a. REC'D BY REGISTRAR				DATE <b>5/20/57</b>			

BUREAU V. S.

MAY 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05307 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>West Rest Home</i> <i>8500 Flower Ave. Takoma Park, Md.</i>				d. STREET ADDRESS <i>5519 13th St. N.W.</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Eleanor Florence White</i>				4. DATE OF DEATH Month Day Year <i>May 29 19 57</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4/12/75</i>	
9. AGE (In years last birthday) yrs <i>82</i>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Government</i>	
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Butler, Pa.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Thomas Bateman White</i>				14. MOTHER'S MAIDEN NAME <i>Jane A. McQuiston</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT <i>Gertrude Wesley, 6750 Eastern Ave. N.W.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Insufficiency</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Atherosclerotic Heart Disease</i> DUE TO (c) <i>Generalized Arteriosclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>May 14 - May 29 (15 days)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>Feb. 1956</i> to <i>May 29, 1957</i> , that I last saw the deceased alive on <i>Mon. May 20, 1957</i> , and that death occurred at <i>1726 Eye St. N.W.</i> from the cause and on the date stated above.							
ACTUAL SIGNATURE <i>Barleen G. Kirkpatrick</i> M.D.				ADDRESS (Street, city or town, state) <i>1726 Eye St. N.W. Washington, D.C.</i>			
PHYSICIAN'S NAME (Type) <i>Barleen G. Kirkpatrick</i>				DATE SIGNED <i>May 29 1957</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>6/1/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince George County, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>				ADDRESS <i>2901 14th St. N.W. Washington, D.C.</i>		24a. REC'D BY REGISTRAR <i>WN 3 1957</i>	
24b. REGISTRAR'S SIGNATURE							

BUREAU V. S.

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**05308 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05430

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>D. O. A.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>			d. STREET ADDRESS <b>9914 Gardiner Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Harold</b> Middle <b>George</b> Last <b>White</b>			4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-2-1899</b>		9. AGE (In years last birthday) <b>57</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman (Bonding Co.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Securities</b>		11. BIRTHPLACE (State or foreign country) <b>Oil City, Pa.</b>	12. CITIZEN OF WHAT COUNTRY? <b>America</b>
13. FATHER'S NAME <b>George White</b>			14. MOTHER'S MAIDEN NAME <b>Leha Causer</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>577-09-1657</b>		17. INFORMANT <b>Mrs. Marian Y. White, 9914 Gardiner Ave., SS., Md.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon monoxide poisoning</b> 473.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(left suicide note)</b> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found in car with hose attached to exhaust</b> 20c. TIME OF INJURY Month, Day, Year _____ Hour _____ o. m. _____ p. m. _____ 19____ 20d. INJURY OCCURRED _____ White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Silver Spring Montg. Md.</b> 20f. (City or town) _____ (County) _____ (State) _____ 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Frank J. Broschart</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>5/11/57</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b> 22b. DATE THEREOF <b>May 13, 1957</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b> 22d. LOCATION (City, town, or county) (State) <b>Prince George's Co., Md.</b> 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Pumphrey</u> ADDRESS <b>Silver Spring, Md.</b> 24a. REC'D BY REGISTRAR <b>5/10/57</b> 24b. REGISTRAR'S SIGNATURE <u>J. Wilson Gould</u>					
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1143. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 81

NY 21 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/

# 05316 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05431

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Stone St., Lincoln Park</b>				d. STREET ADDRESS <b>Stone St., Lincoln Park</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>James R</b> Middle <b>Whitley</b> Last				4. DATE OF DEATH Month <b>May</b> Day <b>22</b> , Year <b>1957</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>col.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 25, 1902</b>	
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Rev. Mercer Whitley</b>				14. MOTHER'S MAIDEN NAME <b>Laura Foreman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Margaret Clogg, 905 Stonestreet Ave., Rockville, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage and laceration</b> 802X DUE TO <b>Compound Multiple Fractures of Skull</b> Conditions, if any, which gave rise to immediate cause (b) <b>sudden</b> (a), stating the underlying cause last. DUE TO <b>Crushed Chest (rt)</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by B &amp; O Freight Train</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>9:45</b> P. M. <b>5/22/57</b> 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>B &amp; O R R</b>	
20f. (City or town) <b>Rockville</b>				20g. (County) <b>Montg.</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>5/25/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Sandy Spring, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert R. Sworde</b>				24a. REC'D BY REGISTRAR <b>MAY 29 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Laurie</b>	

MEDICAL CERTIFICATION

2

RECEIVED

MAY 29 1957

BUREAU V. S.

1

INSTRUCTIONS

1. THE ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy ~~may~~ be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05444

## CERTIFICATE OF DEATH

05432

Reg. Dist. No. 216

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chevy-Chase</u>		LENGTH OF STAY (In this place) <u>7 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chevy-Chase</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7027 Stratmore St.</u>		STREET ADDRESS (If rural give location) <u>7027 Stratmore St.</u>					
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Katharine May Williams</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 25 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 9, 1873</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Weller</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Cunningham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>Mrs. Grace Nicholson Bethesda Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Hypertensive heart disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> years			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>				years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>450.0</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 5-25-57</u> , 19 <u>29</u> , to <u>present</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-25-57</u> , 19 <u>57</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>C.P. RYLAND</u>				DATE SIGNED <u>4400 - 49th ST. NW Wash. 16, D.C. 5-25-57</u>			
23. BURIAL, CREATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5-29-57</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
24. REC'D BY REGISTRAR DATE <u>5-29-57</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son</u>		ADDRESS <u>Hag. Md.</u>	

BUREAU Y. S.

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# STATE OF MARYLAND - BALTIMORE, 18

05445

Item 21 Filed 5-27-57 at  
**CERTIFICATE OF DEATH**

05433  
 Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, give name of institution and residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN TB <b>8 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Russell</b> Middle <b>Thomas</b> Last <b>Williams</b>				4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>19 57</b>			
5 SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>January 12, 1905</b>	
9. AGE (In years, lost birthday) <b>52</b> yrs		IF UNDER 1 YEAR Months <b>52</b> Days <b>23</b> Hours <b>19</b> Min <b>57</b>		11 BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Leadman</b>				10b KIND OF BUSINESS OR INDUSTRY <b>Cable Repairing</b>		11 BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Thomas H. Williams</b>				14 MOTHER'S MAIDEN NAME <b>Bertha L. Earl</b>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16 SOCIAL SECURITY NO. <b>Unascertainable</b>		17 INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.0 Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction &amp; ventricular aneurysm</b> DUE TO (c) <b>Arteriosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)				20g (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 15</b> , 19 <b>57</b> , to <b>May 23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 23</b> , 19 <b>57</b> , and that death occurred at <b>11:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>5/24/57</b> ACTUAL SIGNATURE <b>Emery C. Herman, Jr. M.D.</b> PHYSICIAN'S NAME (Type) <b>E Emery C. Herman, Jr.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a BURIAL, CREMATION, OR REMOVAL (Specify) <b>burial</b>		22b DATE THEREOF <b>5/27/57</b>		22c NAME OF CEMETERY OR CREMATORY <b>Geo. Wash. Cemetery</b>		22d LOCATION (City, town, or county) (State) <b>Pr. Geo. Co., Maryland</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.,</b>				24 RECORD BY REGISTRAR DATE <b>MAY 27 1957</b> REGISTRAR'S SIGNATURE <b>Bessie Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
MAY 27 1957  
BUREAU V. S.



05446

05434

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Rockville</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Thomas</u> Last <u>WIMBERLY</u>				4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>26 Oct. 1956</u>	
9. AGE (In years last birthday) yrs <u>6</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u></u> Min <u></u>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Albert Wimberly</u>				14. MOTHER'S MAIDEN NAME <u>Mescal Braggfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mother, Mescal Wimberly (Same As #2)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular Pneumonia, bilateral</u> <u>752 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Internal hydrocephalus, severe</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>471 X</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>21 Feb.</u> 19 <u>57</u> , to <u>5 May</u> 19 <u>57</u> , that I last saw the deceased alive on <u>5 May</u> 19 <u>57</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>5-5-57</u>							
ACTUAL SIGNATURE <u>Daniel Shugart</u> M.D.				U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) <u>Daniel Shugart, LT, MC, USN</u>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-8-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Lee, 1515 Lincoln Ave., Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>5-6-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

8 1957

RECEIVED

05309

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived; If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington San. &amp; Hosp.</u>				d. STREET ADDRESS <u>804 Maplewood Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Elizabeth</u> Last <u>Witzke</u>		4. DATE OF DEATH Month <u>5</u> Day <u>6</u> Year <u>1957</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucas.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-11-80</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob Hardt</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Ruly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chart</u> Address <u>N.W. 5. H.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>As coming exclusively</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Obesity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Failure</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1945</u> , 19 <u>May 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 6</u> , 19 <u>57</u> , and that death occurred at <u>8:40 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas H. Wolohon</u> M.D.				ADDRESS (Street, city or town, state) <u>500 Underwood St. N.W. DC</u> DATE SIGNED <u>5/6/57</u>			
PHYSICIAN'S NAME (Type) <u>Chas H. Wolohon</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>May 11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CLINTON</u>		22d. LOCATION (City, town, or county) (State) <u>Mo</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Hall</u> ADDRESS <u>1212 P.C. 254 CARROLL ST NW</u>				24a. REC'D BY REGISTRAR <u>5/9/57</u>		24b. REGISTRAR'S SIGNATURE <u>Walter Hall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 10 1957

BUREAU V. S.

05447

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05436

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>6 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hosp.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown R-2</b> d. STREET ADDRESS <b>Estworthy Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Eber Woodruff</b> First Middle Last		4. DATE OF DEATH <b>5/2/57</b> Month Day Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/3/1908</b>
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Editor</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Lakewood, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>EBER BLAINE Woodruff</b>		14. MOTHER'S MAIDEN NAME <b>Helen Herron</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>578-14-0583</b>	
17. INFORMANT <b>Hosp. Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Pulmonary hemorrhage 3500 cc.</b> DUE TO (b) <b>Crushed Chest</b> (c) <b>Auto Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>fractured left leg &amp; cerebral contusion</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car involved in auto accident</b>	
20c. TIME OF INJURY <b>10:30 P. M.</b> Month, Day, Year <b>4/25/57</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	20f. (City or town) <b>Potomac</b> (County) <b>Montg.</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>5/3/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>5-6-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	22d. LOCATION (City, town, or county) <b>Suitland</b> (State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Samuels</b>		24a. REC'D BY REGISTRAR <b>5-7-57</b>	24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1, 2, and 3 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAY 9 1957

BUREAU A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05448

CERTIFICATE OF DEATH

Reg. Dist. No.

05437 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Cherry Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5504 Grove St.</u>				d. STREET ADDRESS <u>15504 Grove St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Warren</u> Last <u>Wright</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 22, 1899</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>57</u> Min.		IF UNDER 24 HRS. Months <u>5</u> Days <u>19</u> Hours <u>57</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>			
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James V. Wright</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Malessa McCarty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Mary H. Wright 5504 Grove St. C.C. Md.</u>			
17. INFORMANT <u>Mary H. Wright</u>				Address <u>5504 Grove St. C.C. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Heart Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 MO</u> <u>10 YRS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>April 15, 1957</u> , to <u>May 3, 1957</u> , that I last saw the deceased alive on <u>April 24, 1957</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Sidney C. Cousins</u> M.D. <u>3931 - Englewood St. NW 5/3/57</u>							
PHYSICIAN'S NAME (Type) <u>SIDNEY C. COUSINS</u>							
22a. BURIAL CREMATION <u>Burial</u>		22b. DATE THEREOF <u>5/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W., Wash. D.C.</u>				24. REC'D BY REGISTRAR <u>8 MAY 8 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. &

MAY 8 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05449

CERTIFICATE OF DEATH

05438

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>8 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SURBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>9302 SUTTON PLACE</u>	
3. NAME OF DECEASED (Type or print) <u>WOOTTON</u> <sup>First</sup> <u>ELDRIDGE</u> <sup>Last</sup> <u>YOUNG</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-1874</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed now -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WHOLESALE TOBACCO</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DALLAS YOUNG</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE</u> <del>ETCHISON</del> <u>ETCHISON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>577-10-5191</u>	
17. INFORMANT <u>MR. EUGENE YOUNG (SON)</u>		Address <u>9300 SUTTON PLACE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 18, 1957</u> to <u>May 26, 1957</u> , that I last saw the deceased alive on <u>May 26, 1957</u> , and that death occurred at <u>9 45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Marion Bankhead</u>		ADDRESS (Street, city or town, state) <u>9241 Col. Blvd</u> DATE SIGNED <u>9/24/57</u>	
PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>		<u>Silver Spring, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/29/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CATH. CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>Silver Spring, Md</u> REC'D BY REGISTRAR <u>DATE 5-29-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO BE OBTAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. L.

LN 3 1957

RECEIVED